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A Practical Guide to Agency E&O Risk Management

Best Practices &
Tips for Insurance Agents

Swiss Re



A Practical Guide to Agency E&O Risk Management

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SEMINAR OVERVIEW

OVERVIEW AND INTRODUCTION

There is no question...more and more insurance agencies are finding themselves faced with Errors and Omissions situations that, at best, result in a time-consuming effort to assemble documents, make statements, and provide proof that the agency did nothing wrong and, at worst, mean going to trial and having the plaintiff awarded damages. When an E&O matter goes to trial, it is the culmination of years of exhausting work, regardless of whether the agency wins or loses the case.

Statistics show that where previously one in twenty insurance agencies would report an E&O claim incident, that number has risen to about one in twelve agencies.

CONTRIBUTING FACTORS TO INCREASE E&O CLAIMS

- ✓ **Product changes.** Insurers are constantly introducing new and more complex coverage forms. Rather than expanding coverage, the changes often result in a contraction of coverage for the insured. Training on the new forms is often limited or lacking, and it is left to agency personnel to decipher the changes and determine the impact on customers. Continuing education, not merely compliance with a state requirement, is key to staying abreast of contract changes.
- ✓ **Changing carrier relationships.** In the past, it was very unusual for a company to sue one of its agents when the company paid a claim it did not feel it would have had unless the agent committed some kind of error. Times and relationships have changed. You can expect that if your agency's mistake causes a company to pay a claim it would not have otherwise been legally obligated to pay, the company may sue you to recover its damages, which may or may not be covered by your E&O policy.

National Claims Statistic: Approximately 5% of E&O claims involve the agent or broker being sued by the carrier.

- ✓ **Strength of the plaintiff's bar.** Agents and brokers are the latest target as a "deep pocket" to pay for otherwise uncovered damages. While insurance companies are likely to fight paying claims they don't feel contractually obligated to pay, insurance agents and brokers often seek to settle E&O claims to avoid embarrassment and future loss of revenue.

A Practical Guide to Agency E&O Risk Management

- ✓ **Reasonable client expectations.** Previously, an insured looked to their insurance policy to protect against catastrophic losses. Now, they want protection for losses that may not even be insurable. There are a number of cases against insurance agents based on the theory that the consumer has been harmed because they “reasonably expected” to be covered for the loss. Ultimately many losses are covered...either by a policy the insured purchased and paid for, but if not, many will seek recovery from the agency’s E&O policy.
- ✓ **Changing client relationships.** Now that agents are considered as professionals in many arenas, they are treated as such in those places. In these instances, the standard of care may be higher for agents and brokers. In addition, the existence of a “special relationship” between an insured and an agent or broker can be used against an agent in an E&O case. A special relationship may be found to exist when the agent has written the account for a very long time, has a personal as well as a business relationship with the client, or has special knowledge about the business of the client.
- ✓ **Emerging exposures.** Internet liability, environmental impairment, identity theft, and other new and emerging exposures call upon an agent to be a master of many coverages in an environment where coverages are constantly changing and it is difficult or impossible to have extensive knowledge of all of them. Constant vigilance is required to remain aware of which companies are available to write what coverages, what new coverage is available, and how to communicate the state of the marketplace to consumers.
- ✓ **Consumer demands.** We are all consumers and we all want everything faster, better and cheaper. The insurance consumer is no different. If speed sometimes trumps accuracy, an E&O exposure may arise for the agency.

Errors and Omissions insurance companies typically categorize agents’ E&O claims based on the “cause of loss.” The data shows that most losses are caused by claims that an agent failed to offer, obtain or maintain requested insurance coverage on behalf of a client. Some people believe that nearly 100% of agency E&O claims happen when a customer did not have any or adequate insurance for a loss. But just knowing that fact does not give an agency owner, manager, or staff member any practical tools to mitigate E&O losses—something more must be done.

SEMINAR OBJECTIVES

- ✓ To provide practical, real-world E&O loss prevention and reduction techniques
- ✓ To alert the participant to the recent trends in agency E&O claims
- ✓ To direct agency personnel to the tools and resources available to assist in E&O loss control

The material for this course is presented in modules. Depending on the time frame and the presenter, you may cover several or all of the modules during your seminar. Any material not covered during the seminar is available as a reference to you once you return to your agency.

Our overall goal, which we know you share, is to reduce the number of times an agency is called upon to defend itself and its actions. We believe that excellent service, from the moment we first enter into a client relationship, will result in fewer E&O claims and therefore the focus of this course is on what an agency should be doing proactively, rather than dwelling on what an agency should avoid.

WHAT IS A “BEST PRACTICES” APPROACH?

For many years, some independent insurance agents had limited resources to use to manage their agencies. Although they were bombarded with data and seemingly meaningful statistics, agency owners were forced to manage to information that often consisted of nothing more than averages of agency results nationwide. What’s wrong with averages? Well, nothing, except that they’re just that...average. If you use them to manage your agency, even if you achieve the result, you will just be mediocre.

The Independent Insurance Agents & Brokers of America (IIABA) Best Practices Study, begun in 1993 and updated every year since, changed the way we think about agency management. Rather than survey thousands of agencies across the country, IIABA sought out the cream of the crop, the best of the best, the so-called “Top Guns” among independent insurance agencies. The result is that we now have a moving target at which to aim, constantly changing and improving, based on results obtained from the finest performing agencies in the country.

Not surprisingly, the best agencies also have better than average E&O loss ratios. It’s not that they are immune from E&O—it’s just that they seem to have better internal processes and procedures that make losses less likely to happen, and reduce the financial impact on the agency when they do occur.

In designing this seminar, we have looked to these Best Practices agencies to provide each of you with ideas and suggestions to help you limit your E&O exposures. In many cases, by adopting some of the Best Practices methods and tools shown here, you will also improve other results for your agency including operational efficiency, enhanced customer service, and improved financial performance.

2009 Best Practices Study Update Available (\$99.95 hard copy and \$59.95 electronic copy) - The 2009 Best Practices Study Update provides critical performance benchmarks in seven agency revenue categories. Agencies can measure, evaluate, and compare results for agency operations including income and expense distribution, revenue and profitability growth, production and service staff compensation, technology expenses, carrier representation and more.

Visit the “Best Practices” tab on www.independentagent.com to learn more.

SEMINAR FORMAT

As we stated earlier, this seminar is presented in a modular format, allowing the presenter and the attendee some flexibility in deciding which topics will be covered in what depth. Certain core modules will be a part of every seminar.

Ultimately, the only way to improve your agency's results in any area, whether it's reducing risks of E&O claims or anything else, is to change. Therefore, the main objective of this seminar is to change behavior. The focus is on results.

Since we are using a Best Practices approach, the seminar will include:

- ✓ Practical, real-world solutions to current E&O issues
- ✓ Sample practices and procedures that can be implemented in any agency (including samples for your use)
- ✓ Tools and resources that can assist you, including self-audit forms and some guidance on how to deal with E&O claims that do arise (of course subject to the direction of your E&O carrier)
- ✓ Case studies drawn from actual E&O claims
- ✓ Emphasis on current trends and issues, including technology and automation

There are no scare tactics, threats, or intimidation, simply an examination of the issues and an attempt to arrive at ways to provide excellent service to our customers while minimizing our risk of errors and omissions claims.

This seminar will use a risk management approach, much like we use with our customers every day. We will assist you in identifying potential E&O exposures, analyzing and measuring those exposures, deciding on an appropriate method to handle and minimize the risks, and implementing the chosen method. Implementation is key!

E&O exposures can be created by anyone in an agency, including owners and managers, producers, and support staff. You will note that throughout this seminar, we have included three different sections when creating an agency action plan:

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- ✓ What the CSR can do to prevent E&O losses
- ✓ What the producer can do to prevent E&O losses
- ✓ What management can do to prevent E&O losses

The goal is to raise everyone's awareness of how E&O claims arise. Through a concerted effort and open dialog on the part of everyone in the agency, E&O prevention is attainable.

ACTION LIST

The most important thing you can do to prevent or reduce E&O claims is to take action in areas where your agency is currently underperforming. If you are not the decision maker in your agency having an open dialog on your ideas for improving the agencies operation with them is extremely worthwhile. Based on what you have learned from this seminar, list the changes you think are important for your agency to consider implementing:

ACTION	RESPONSIBILITY	TARGET COMPLETION DATE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Circle your TOP THREE action list items to consider first.

Feel free to provide a copy of this action list to your state association following the seminar. They may know of some tools to help you accomplish your action items. A confirmation that the items have been completed can also be furnished to the state association approximately six months later. This will demonstrate your commitment to E&O risk management and can help you stay on track with your agency improvement goals.

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CAUSES OF E&O LOSSES

The following pages contain the latest claims data gathered from Swiss Re, the nationally endorsed E&O carrier for the Big “I” Professional Liability Program and the largest provider of insurance agent’s errors and omissions coverage in the United States.

Data is presented in the following manner:

- ✓ Claims Frequency by Type of Underlying Policy
- ✓ Claims Frequency by Point in Customer Life Cycle or Process Step
- ✓ Claims Frequency by Agency Position
- ✓ Claims Frequency by Type of Transaction
- ✓ Claims Frequency by Type of Coverage
- ✓ Claims Frequency by Type of Error

While interesting, the data itself is not necessarily instructive as to what an agency can do to prevent E&O claims. Therefore, it is necessary to dig deeper to understand the **root cause** of E&O losses and implement change at that level.

Ultimately, E&O losses occur because of inadequate training and education, poor risk identification and analysis, lack of uniform practices and procedures, inappropriate organizational structure, lack of compliance with office practices and procedures consistency, time constraints and/or chronic backlog.

Problems with Organizational Structure

Many E&O claims are the result of miscommunications or incomplete transactions between agency staff members. The more people who must touch a transaction to complete it, the more likely something will not get done as it should. In an automated world, organizations should be flatter and look for ways for transactions to be handled start to finish by the same person. Whenever a transaction is passed from person to person, the potential is increased for someone to “drop the ball” and this is a point of E&O vulnerability.

What Management Can Do

- ✓ Create an organizational chart of all positions in the agency
- ✓ Make sure every employee has a current position description and list of position qualifications that details the expectations of each person

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- ✓ Examine if the agency is structured vertically (lots of layers) or horizontally (lots of peers) and consider which structure would be most effective
- ✓ Reorganize the agency's workflow based on the tasks that must be completed and determine who is best qualified to complete each task

Lack of Uniform Practices and Procedures

Most people, in order to perform their job to the best of their ability, require some kind of structure or "roadmap." In most agencies, however, there are no written practices and procedures. Without written guidelines, agency personnel are forced on an ad hoc basis to use their own best judgment in a variety of circumstances. While their judgment may be generally sound, problems occur when each person develops their own system of operation, some being better (or more dangerous) than others. Some agencies are actually an amalgamation of several smaller agencies, all operating under the same roof, and each of these mini-agencies may have its own way of doing business, which may or may not be appropriate. Consistency in practices and procedures regarding how business is done is a critical component in E&O claims prevention.

What Management Can Do

- ✓ Train all employees in office practices and procedures
- ✓ Form a committee to update old office practices and procedures or research available options to create agency practices and procedures (purchase of templates, hiring a consultant, etc.)
- ✓ Determine how adherence to practices and procedures will be reviewed or audited, by whom, and when – this can be accomplished by audits of customer files, using standard reports available within your agency management system (refer to the module on Documentation for examples)
- ✓ Include adherence with practices and procedures as consideration in each person's compensation plan and the performance review
- ✓ Many agency E&O applications ask if agencies have a procedures manual. This is not your agency management system manual. Answer this question truthfully and if you don't have a practices and procedures manual you should consider getting one. The assumption is that a "yes" answer means the procedures are up to date and enforced throughout the agency. Your local state association can you assist you with the manuals available in the marketplace.

Lack of Compliance with Office Practices and Procedures

Even if an agency has good practices and procedures in place, they are not helpful if agency personnel fail to adhere to them and this creates a real exposure to E&O claims. In some instances and depending on the issue and its relation to a potential claim, an agency may actually be better off having no procedures than having to admit, under oath, that there is no requirement that they be followed, or any consequence if they are not. Consistent practices and procedures should be applied to reduce the chances of errors and to provide the service intended to the agency's customers.

What Management Can Do

- ✓ Determine how adherence to practices and procedures will be reviewed or audited, by whom, and when
- ✓ Consider conducting periodic audits to ensure adherence to agency practices and procedures
- ✓ Make sure every employee has a current position description and list of position qualifications that details the expectations of each person
- ✓ Provide a service schedule to each customer, and use your suspense system to make sure services are provided when appropriate
- ✓ Include adherence with practices and procedures as consideration in each person's compensation plan and the performance review
- ✓ Create an agency management activities report to monitor adherence to agency practices and procedures on a periodic basis

Inadequate Training (Education, Education, Education)

Very few people intentionally do things wrong. Rather, they presume they are acting appropriately. Inadequate training can include a lack of understanding of the customer risk analysis process, inadequate product knowledge, and unfamiliarity with the agency management system. There are many reasons (excuses) put forth by agencies as to why their personnel may not be adequately trained, but the most common are lack of time, lack of resources, or lack of motivation. Imagine going to a doctor who has not completed the journey from student to intern to resident to practicing physician. The stakes are no less high in insurance and we want our customers to work with the best people available to meet their insurance needs.

What Management Can Do

- ✓ Improve your employees' insurance IQ by providing every employee in the agency with access to the Big "I" Virtual University (www.independentagent.com/VU) including access to the "Ask the Expert" service.
- ✓ Prepare a career education path for each employee in the agency so the employee remains qualified to fulfill their responsibilities and provide rewards for attaining each milestone—and consequences for failure to achieve each goal.
- ✓ Provide training for each person that goes beyond the typical continuing education class to simply maintain their insurance license. This may include classes such as time management, computer literacy, and effective organizational habits which are often not approved for continuing education credit.
- ✓ Consider appointing a mentor for each new hire—not just the person who has been at the agency the longest—and hold the mentor accountable for helping teach the new person the "agency way" of doing business
- ✓ Develop and formalize your orientation program for new hires to ensure they are acquainted with the agency's history and philosophy as well as its way of doing business, including where to get guidance, help when needed, and to share ideas. Make sure new employees understand the impact errors and omissions in their servicing of the business can have on the long-term success of the agency.
- ✓ Hire the right person for the job.
- ✓ Lead by example—maintain a culture within your agency that promotes professional development, such as through formal and other education classes, journals, and peer contact is important.

Time Constraints

When examining E&O claims that have been made, it is often stated by agency managers and staff members that the real reason something was not done or that it was done incorrectly is that the person or persons involved simply didn't have enough time. Most people feel that their agency is understaffed and that all problems would go away "if only we had more people." Generally, insufficient staff is not the problem. Rather, it may be the ability of staff to manage the tasks that must be completed and use the tools available to free up time to complete all tasks required.

What Management Can Do

- ✓ Compare your agency's Revenue per Employee (RPE) with the appropriate category of Best Practices agencies
- ✓ If your RPE is low, but people still feel overworked, you may not be utilizing automation properly, may need to re-evaluate and redistribute the workloads in the agency, and may need to have certain staff trained in the tools and resources that will allow them to be more efficient.
- ✓ If your RPE is very high, you can still be understaffed and people are just processing items without thoroughly reviewing them. So try to look behind the productivity in your agency to understand what is really happening and respond accordingly.

Chronic Backlog

Our industry is unique in that there is a specific "buying date" for most of our transactions. Policies renew and must be "purchased" on a certain date, new vehicles, equipment or buildings must be covered on the day the insured takes ownership, and claims must be reported by the agency to the carrier promptly after reported to the agency. Therefore, our ability to manage and prioritize our work is of utmost importance. Some tasks, like checking new policies when received, or processing some kinds of endorsements, may seem to be less urgent and get put aside. The truth is, all agencies can and should target to operate with reasonable turnaround for every transaction. When items are not processed in a timely manner, it leads to inefficiency and, potentially, E&O claims.

What Management Can Do

- ✓ Determine the extent of backlog in the agency by auditing each person's work including suspense items that have been moved forward but not completed
- ✓ Consider developing service targets, such as number of days for processing items received, return of phone calls, claims reporting, etc.
- ✓ Develop a system of work flow management that will permanently eliminate backlog and a reporting system to determine when deadlines are not being met
- ✓ Monitor each person's work to ensure targets are being met (Note: Consider including language in the agency's office human resource manual that states the rights of the agency to audit and review work on employees desk or system.)

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Hiring the Right People

When an E&O claim occurs, you can sometimes isolate it to an individual or group of individuals who may have contributed to the loss. Keep in mind it probably was never the intent of these people to cause harm to the agency. Rather, it probably was the result of a lack of training or compliance with procedures. But how can an agency know if they have the right person in the right position?

What Management Can Do

- ✓ Test all sales or service people before hiring them to see if they have the basic aptitude to do the job

Big “I” Advantage Products and Services – Resources

Caliper:

The Big “I” works with Caliper to offer members help in matching people goals to business goals. Caliper can help you to select, manage and develop people and understand the gaps between where you are versus where you want to be with their personality profile assessment. This provides plenty of insight to get the right person for the job. Visit www.independentagent.com/caliper for more information.

Big “I” Career Center:

The Big “I” Career Center offers a premier electronic recruitment resource for the industry. Employers and recruiters can access the most qualified talent pool with relevant work experience to fulfill staffing needs. Visit www.independentagent.com/careercenter for more information.

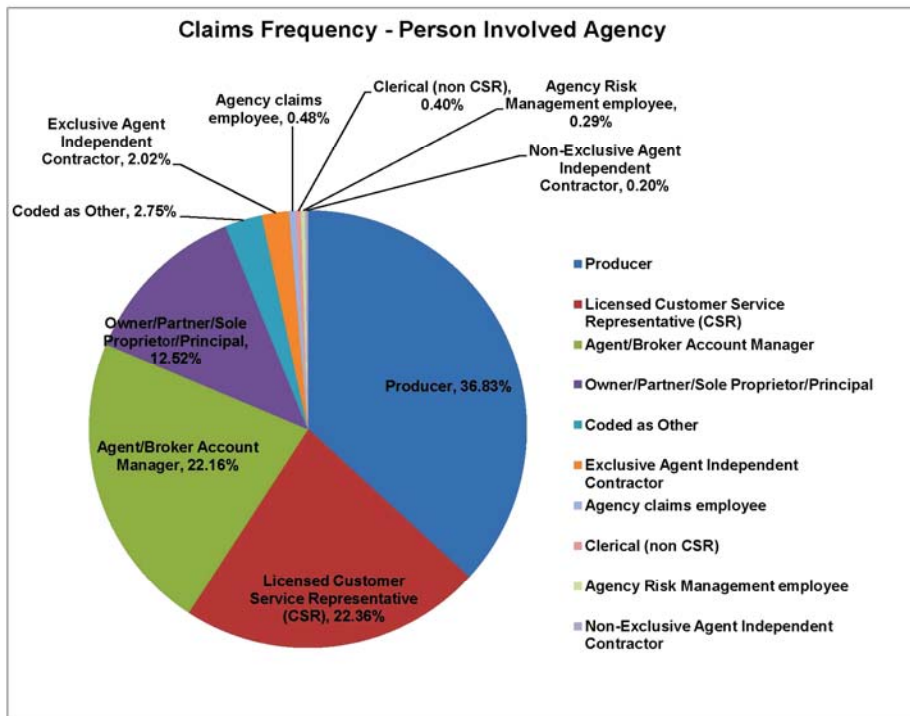
- ✓ Give tests to applicants to assess their technical/product knowledge
- ✓ Provide position descriptions for every applicant and employee in the organization and update them as needed
- ✓ Conduct a new employee orientation that emphasizes adherence to procedures, E&O loss control, and continuing education

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Review of the Claims Data

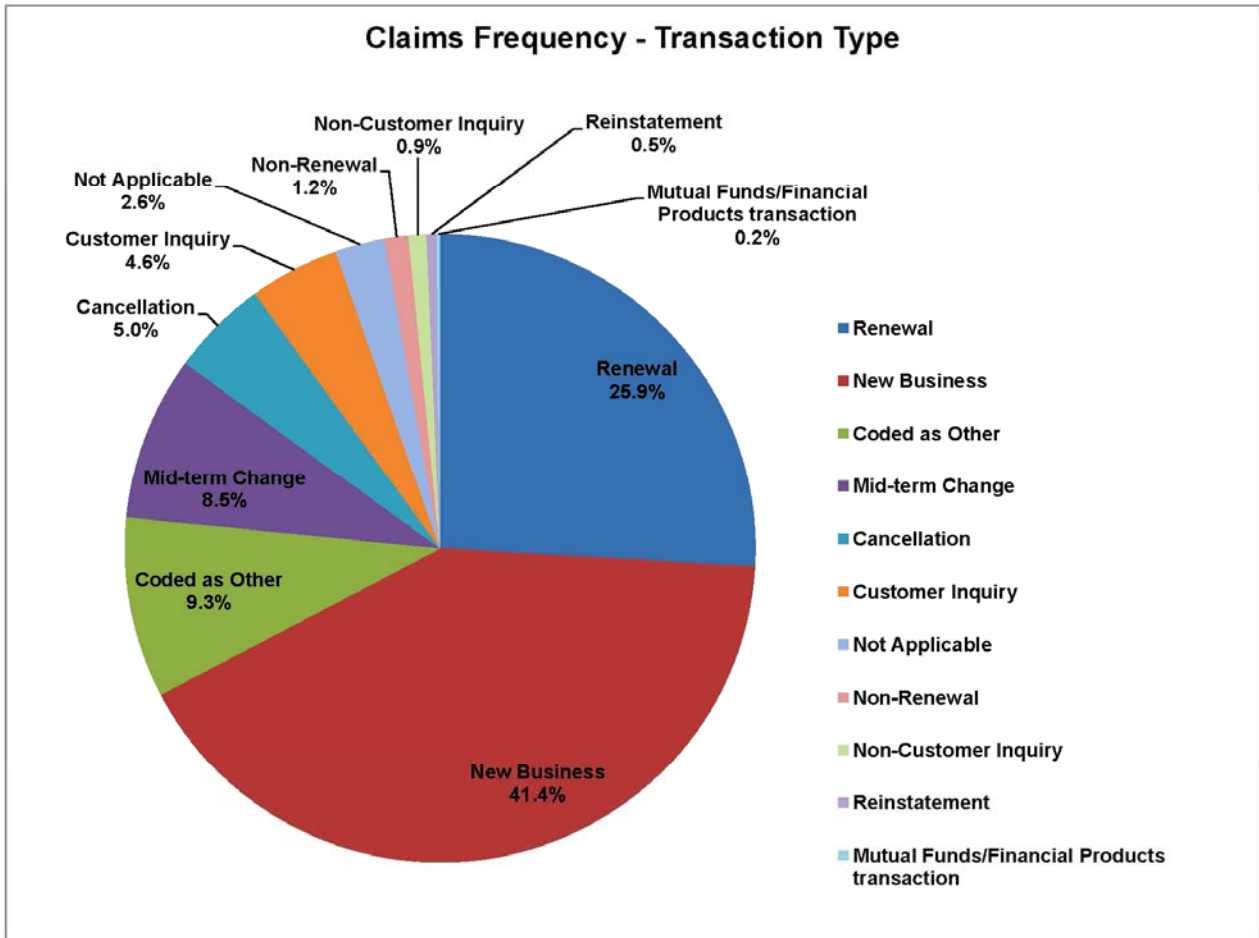
Aggregate Claims Data Provided by Big "I" Professional Liability Program and its nationally endorsed carrier Swiss Re

Claims Frequency by Agency Position



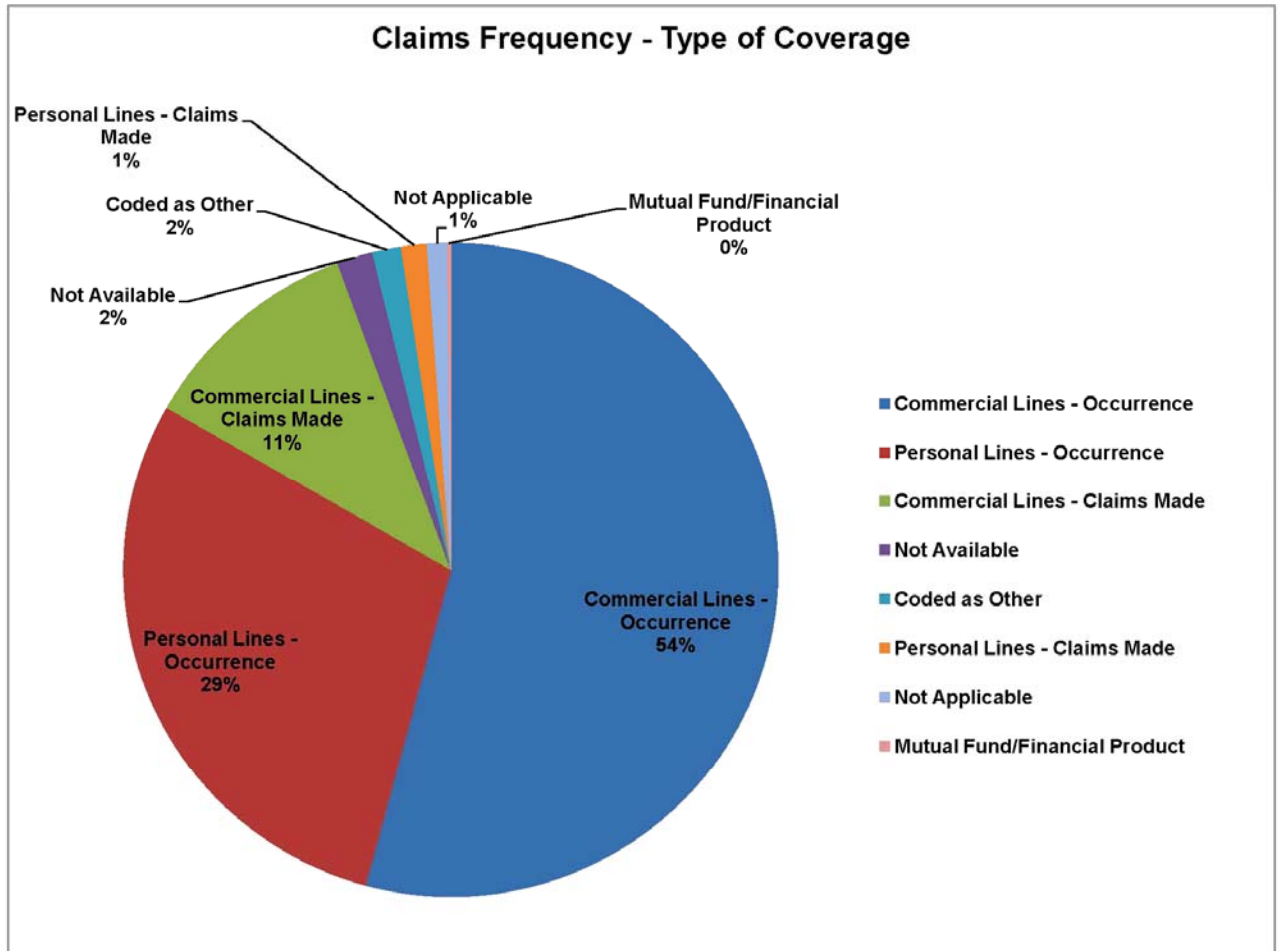
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Claims Frequency by Type of Transaction



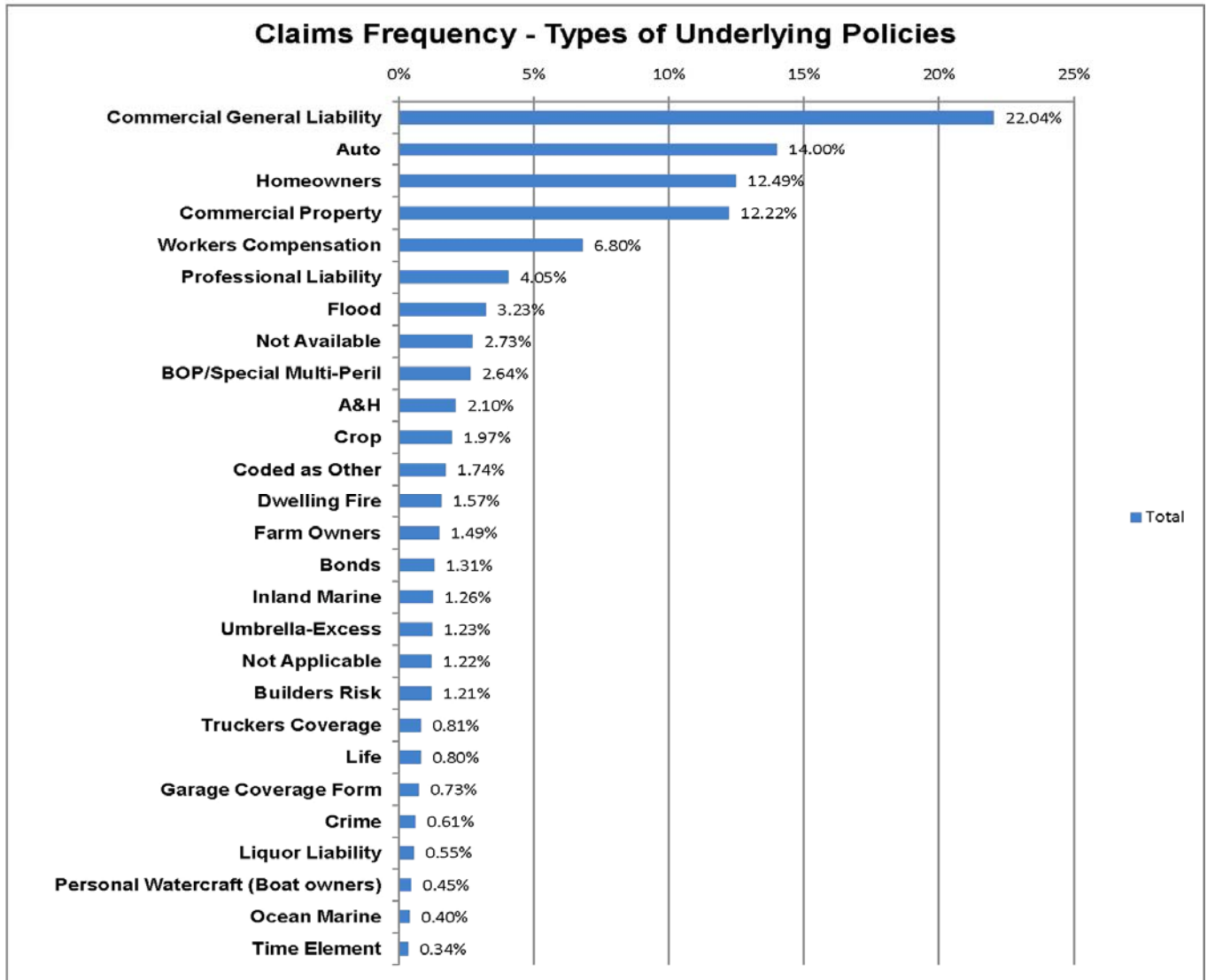
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Claims Frequency by Type of Coverage



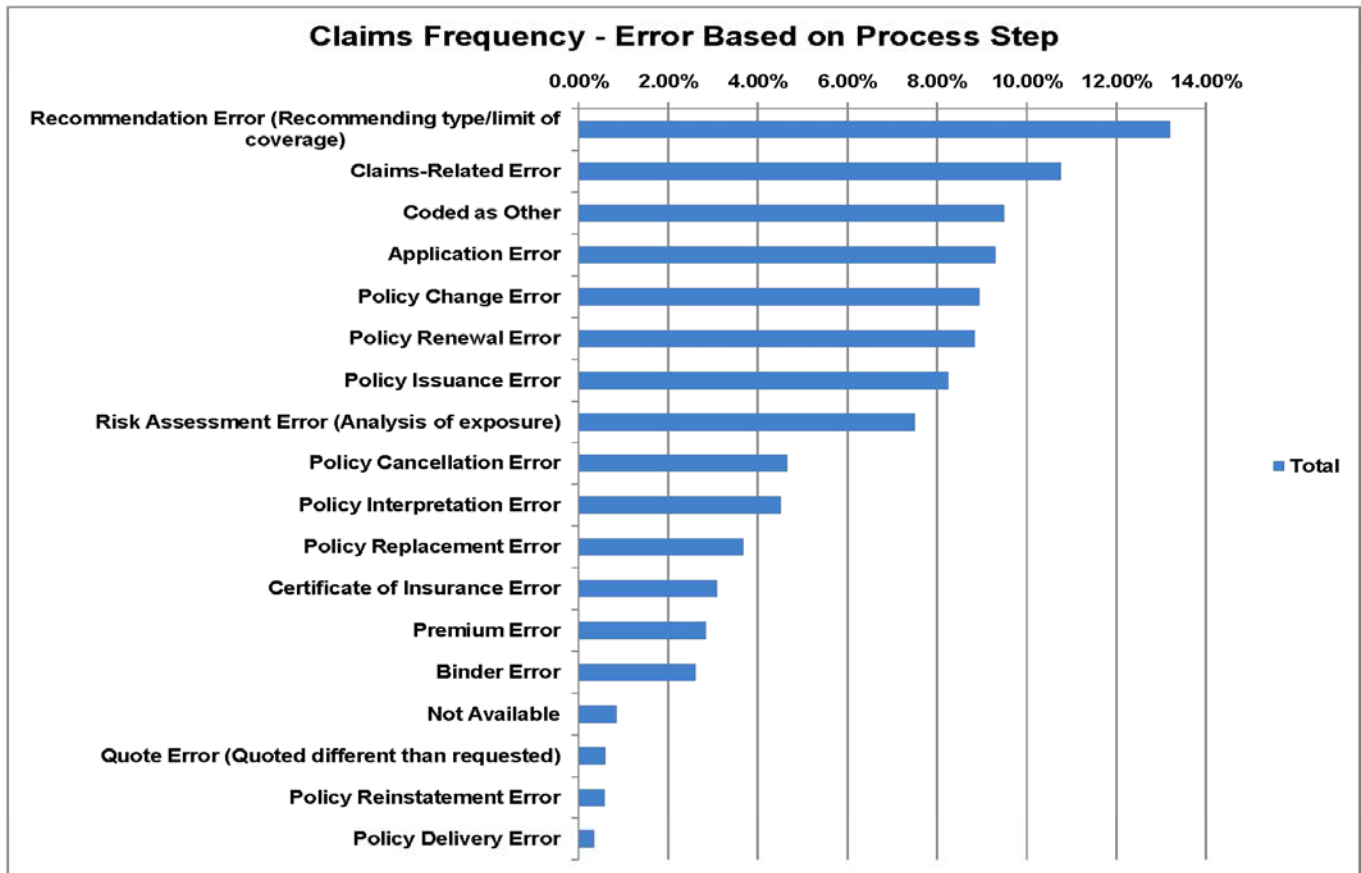
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Claims Frequency by Type of Underlying Policy



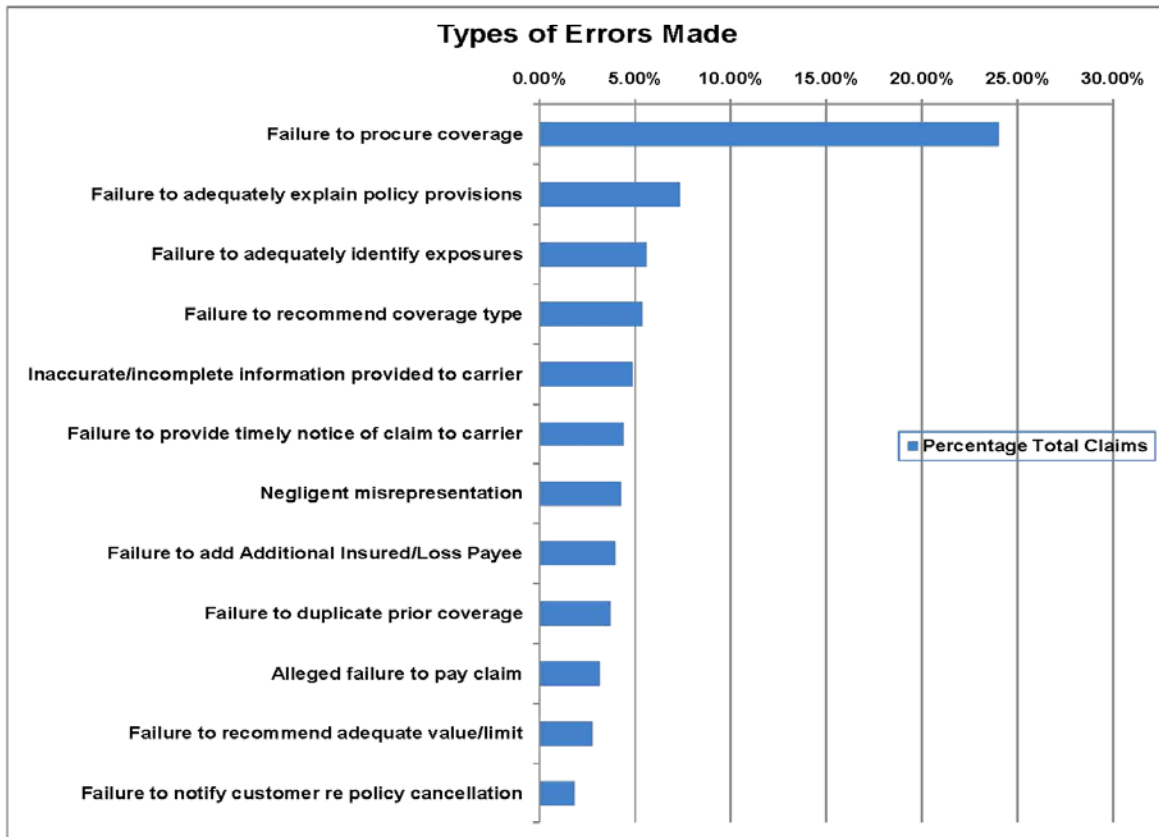
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Claims Frequency by Point in Customer Life Cycle or Process Step



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Claims Frequency by Type of Error



AGENTS' AND BROKERS' STANDARD OF CARE

If you ever feel that as an insurance agent, regardless of your position in the agency, you are between the proverbial "rock and the hard place", you're right to feel that way. An insurance agent's standard of care is determined by law. In addition, some agents go beyond that based on Best Practices, as determined by studies of other insurance agencies.

For many years, many insurance agents sought to be treated on the same plane as accountants, attorneys, physicians, bankers, etc. As recognition of the insurance agent as a professional is finally achieved, it comes with a price tag of an expectation that the agent meet standard of care attendant to that or face legal action from his or her customers or their insurance company partners.

The fact that every state requires that an agent be licensed to sell, negotiate or transact insurance assumes he or she will have the requisite knowledge to perform the activities necessary to provide this complex product to the insurance-buying public.

The duties of an insurance agent are derived from a number of sources:

- ✓ **State laws**, such as state statutes and regulations primarily imposed by the insurance and other laws of the agent's or broker's state, as well as reported cases in the state
- ✓ **Contractual duties owed to insurance companies** for whom the agent has agreed to be the legal or authorized representative under an agency or brokerage agreement
- ✓ **Contractual duties owed to the agent's or broker's customers** based on agreements to perform certain tasks as prescribed by law
- ✓ **Duties owed to third parties** that arise out of an action or inaction on the part of the agency

State Laws

Agents under state law typically are covered in code sections and regulations concerning insurance and businesses and in general Unfair Trade Practices laws which are not geared specifically to one industry but are more general in nature. Most often unfair trade practices are used when there is no other specific duty under insurance statutes or regulations. The basic intent of the laws is to prohibit unfair or deceptive practices in soliciting, selling, or servicing insurance.

Some examples of the acts to consider avoiding and that may give rise to claims against an agent based on state law (statutes/regulations and case law) include:

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- ✓ Misrepresenting the terms of an insurance policy
- ✓ Making false or misleading statements as to dividends or other returns to be paid under a policy
- ✓ Misrepresenting the financial condition of an insurance company
- ✓ Using the title of a policy to misrepresent its true nature
- ✓ Making misrepresentations to a policyholder to induce them to surrender, forfeit or allow any policy to lapse
- ✓ Making false advertisements or providing false information about any person in the business of insurance
- ✓ Defaming an insurance company in any way to injure its business reputation
- ✓ Falsifying records, books or documents with the intent to injure or defraud anyone
- ✓ Selling or offering any shares, securities, or bonds promising returns or profits as an inducement to buy insurance
- ✓ Discriminating in favor of individuals among insured persons of the same class as to rates, dividends, benefits, or other terms of insurance contracts
- ✓ Discrimination in property and casualty insurance based solely on geographic location
- ✓ Discrimination in insuring residential property based solely on the age of the property
- ✓ Making a rebate of all or part of the premiums payable on a policy or giving or receiving any valuable consideration as an inducement to purchase insurance

Contractual Duties to Insurers

We sometimes make light of the difference between the terms “agent” and “broker”, but there can be very significant legal distinctions under the laws of some states.

An *agent* is the legal, authorized representative of the insurance company (principal), and as such owes a fiduciary duty to the insurer. The extent to which any additional duties are created that flow from the agent to the insured is determined by state law and may vary by the circumstances. For example, under the laws of a state, the agent may owe a duty of

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reasonable care and skill, or good faith and fair dealing to the insured even without a fiduciary duty to the insured.

A *broker* is the legal representative of the insured (except for collection of premiums) and owes a fiduciary duty to the insured. The extent to which any additional duties are created that flow from the agent to the insured is determined by state law and may vary by the circumstances. For example, under the laws of a state, the agent may owe a duty of reasonable care and skill, or good faith and fair dealing to the carrier even without a fiduciary duty to the carrier.

The duties owed by an insurance agency to an insurer include:

- ✓ Comply with the terms of the agency agreement
- ✓ Follow all underwriting guidelines provided to the agency
- ✓ Accurately disclose all known risks and material information

National Claims Statistic: Approximately 5% of E&O claims are generated from the insurer bringing claims against agents.

E&O claims brought by insurers against insurance agents based on alleged breaches of the duties described above include:

- ✓ Failure to follow underwriting guidelines provided to agents or exceeding authority provided to agents
- ✓ Failure to exercise reasonable care in discharging its duties to the insurer
- ✓ Failure to act in the best interest of the insurer
- ✓ Failure to revise coverage upon request
- ✓ Failure to cancel coverage upon request
- ✓ Failure to disclose known material information

The authority of an agent or broker to act on behalf of an insurer is contained in the agency or brokerage appointment agreement. Authority arises in the following ways:

Express Authority

The appointment contract entered into between the insurance company and the agent spells out the authority that is granted to the agent. That express authority typically includes such things as:

- ✓ If the agent has binding authority
- ✓ The time frames for transmitting documents to the insurer
- ✓ The manner in which premiums collected by the agent must be sent to the insurer

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If these express authorities are exceeded by the agent, a cause of action may exist by the insurance company against the agent for a breach of contract.

Implied Authority

Authority sometimes arises for an agent out of circumstances, even though it is not spelled out in a contract or agreement. Typically, implied authority is that which is required for an agent to exercise its express authority. For example, an agency agreement may specify what type of coverage may be bound by an agency, but it may not say that the manner in which this is to be accomplished is to use an ACORD binder. The use of the binder would be implied authority of the agent.

Apparent Authority

Apparent authority arises when someone holds themselves out as being in a position to have authority for a particular course of action, even if that is not the case, and another person reasonably relies on that as a basis for their actions.

Imagine that an independent agency advertises that it represents a certain insurance company. A prospect approaches the agency and requests coverage with that company, based on past positive experience with them. The agency gives the new policyholder a binder showing the insurance company they requested. Although the agency had no actual authority to bind that company, the consumer was reasonable in relying on the representation of the agent that it had the authority to issue the binder. If the insured is involved in an accident on the way home from the agent's office that would be covered by the insurance he reasonably believed was properly bound, the agency would be exposed to liability to the carrier for the claim if the carrier is found liable, and to the insured, for the misrepresentation for damages not otherwise recovered.

While it was most unusual for an insurance company to pursue an E&O action against one of its agents in the past, that is not true today. If an agent, through his or her negligence, causes a loss to the insurance company to which he or she is contracted, that company may pursue an action against the agent for reimbursement of any loss paid to the insured.

Contractual Duties to Customers

Brokers may have a variety of contractual duties to their customers. Some contractual duties typically owed by a broker to its customers are to:

- ✓ Obtain coverage as requested by the customer
- ✓ Carry out instructions of the customer using reasonable care and skill

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- ✓ Advise the customer in a timely manner if coverage desired by the customer cannot be placed
- ✓ Advise the customer in a timely manner if coverage desired by the customer cannot be renewed

One of the areas of potential liability for agents is the failure to identify an uninsurable exposure the customer has. This risk can be reduced or avoided by a thorough review of a customer's exposures such as:

- ✓ Physical inspections of property/risks to be insured (to the extent that the agent is trained about what to look for)
- ✓ Interviews with the customer's key personnel
- ✓ Review of financial statements
- ✓ Have the customer provide you with the insurance requirements of contracts, agreements with vendors, suppliers, landlords, tenants, and others
- ✓ Review of the customer's advertising materials, brochures and website to gain a complete understanding of the insured's or prospect's operations
- ✓ Flow charts created by the customer to understand the basic processes of the prospect/customer
- ✓ Surveys and checklists provided by an insurance or risk management organization

The number one cause of E&O claims is the allegation that there was a "failure to procure requested insurance". This may arise in many ways, including if the broker fails to recognize exposures that may be unique to the type of business they are writing and insurance that they could and should have recognized.

Even as we are writing this material, litigation is being played out in the state courts stemming from potentially uncovered losses for which the insureds seek reimbursement. It is impossible to predict if these lawsuits will be successful, but even if they are not, the cost and time to defend them is expensive in actual dollars as well as the time spent away from the business and its growth.

Duties Owed to Third Parties

In the past, the courts would look to a legal concept called "privity" to determine if a party was legally obligated to another under contract. This meant that only the parties most directly entering into a contract could be held responsible if the contract failed. Privity in insurance would have limited an agent's or broker's legal responsibility to a party other than the insured or the insurance company.

Like many other legal concepts, this one has been breached by the courts and therefore creates an additional E&O obligation on the part of insurance agents and brokers.

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The duties owed to third parties by insurance agents and brokers include:

- ✓ Determining the other party's interests to be protected (e.g., bank, mortgagee, loss payee, etc.)
- ✓ Advising other parties of failure to obtain coverage as requested
- ✓ Using an appropriate degree of skill and care in performing his or her duties to a third party

The vast majority of third-party suits against insurance agencies involve certificate holders, lien holders or mortgagees. They typically involve the evidence of insurance provided by the agency. As such, you should refer to the Certificates of Insurance Module for additional information.

THE CUSTOMER LIFE CYCLE

As pointed out in a previous section, Errors and Omissions losses can be categorized based on when they occur in the course of doing business with a customer. This is referred to as the Customer Life Cycle and consists of:

- ✓ Marketing and selling
- ✓ New business (including quoting, binding, and issuing policies)
- ✓ Endorsements (additions, deletions, and other changes)
- ✓ Claims
- ✓ Renewals
- ✓ Cancellations and nonrenewals
- ✓ Audits

E&O losses can occur anywhere in the cycle. As our data shows, however, most claims are generated from placing new business for a new or existing customer. Renewing policies generates the second largest number of claims. This is to be expected since it represents the vast majority of transactions processed by an agency.

We will examine each of the steps in the Customer Life Cycle to see what an agency, producer or CSR can do to prevent or reduce the potential for an E&O claim.

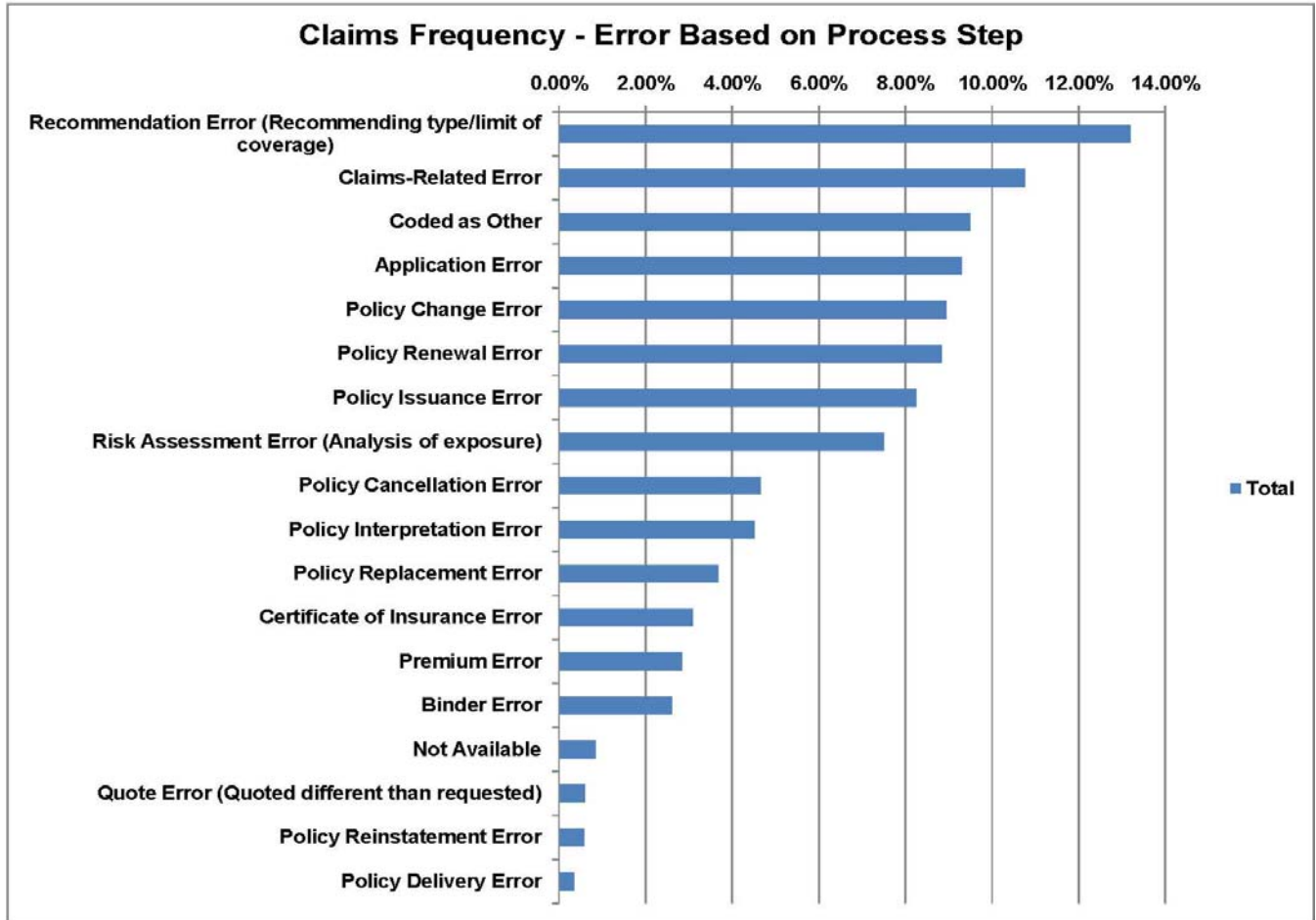
Marketing and Selling

Marketing is everything that leads up to a one-on-one opportunity to sell insurance. This includes advertising, promotions, and other attempts to increase the name recognition of the agency.

Selling takes place when a willing buyer and willing seller meet in the marketplace and agree to the terms of a purchase/sale. In insurance, this requires activities such as establishing relationships with prospects, gathering underwriting information, preparing submissions to insurers, delivering proposals, and making presentations.

Types of E&O Claims

Below is some data from the Big "I" Professional Liability Program relating to process steps in the marketing and selling process:



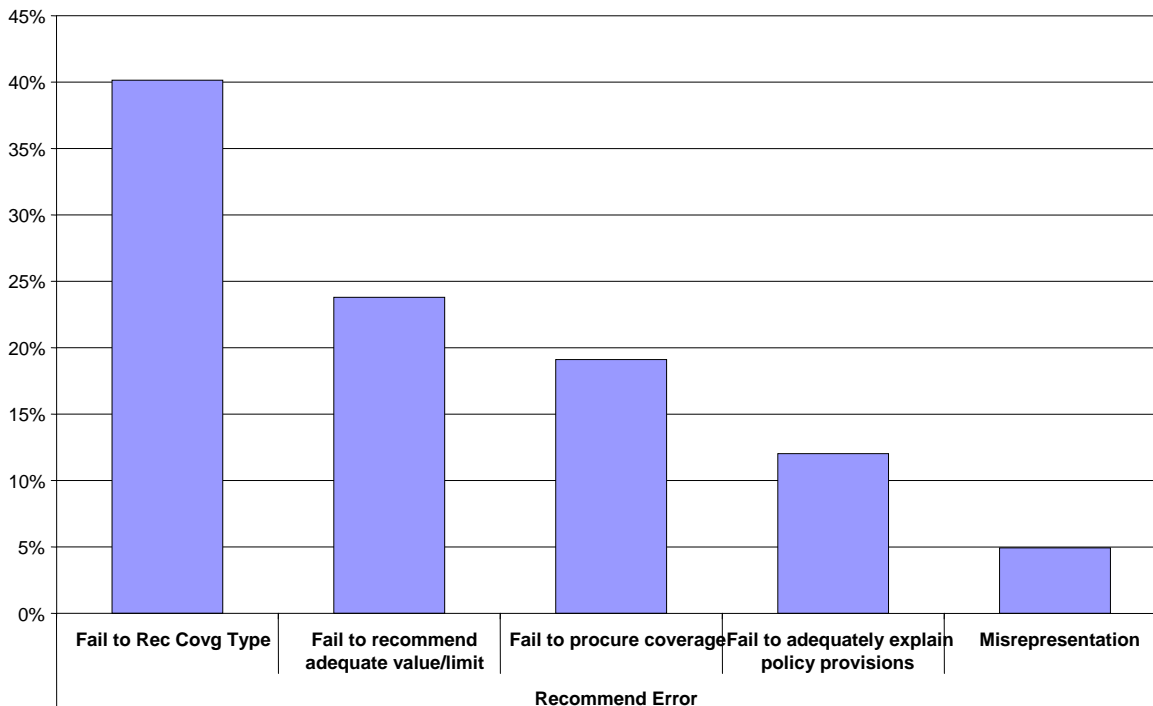
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More specifically the types of losses that occur in marketing and selling insurance typically involve:

- ✓ Failure to identify a loss exposure and propose a risk management solution

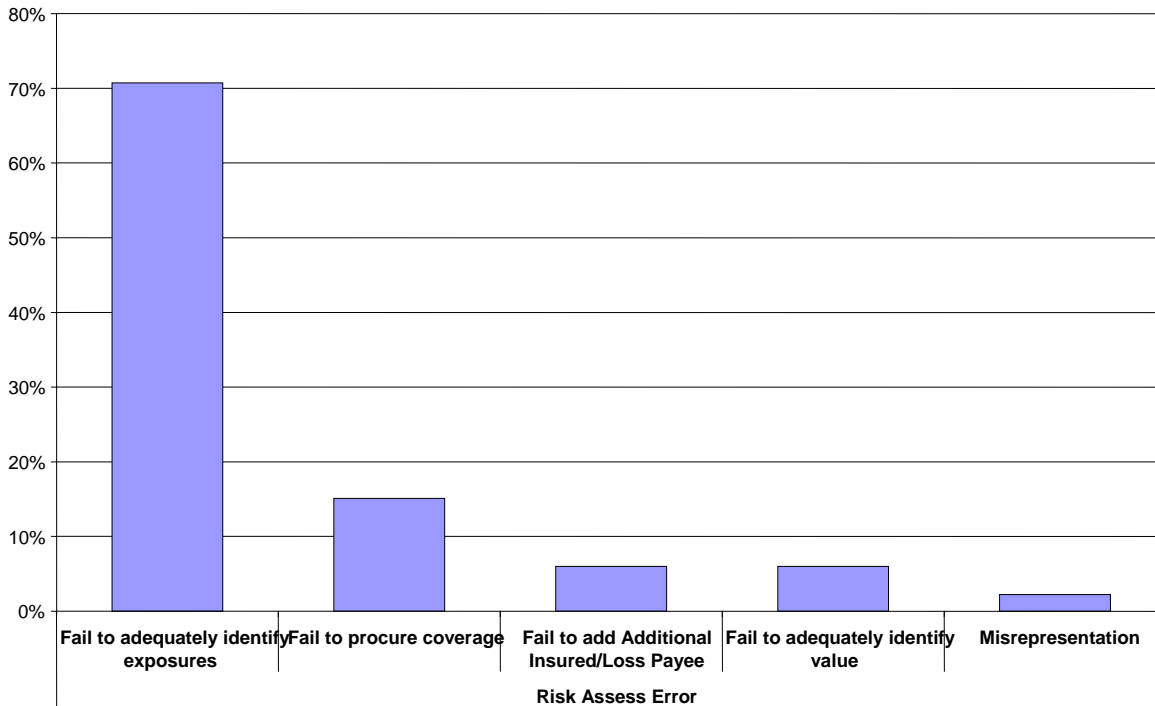
National Claims Statistic: The largest portion of E&O claims occur during the recommendation process step at approximately 15% of E&O claims. Risk assessment process step errors make up about 8%. Thorough risk analysis is an important practice for your agency to implement during the marketing and selling process. Below are the top 5 errors for the recommendation and risk analysis process steps.

National Agent E&O Claims Frequency - Top 5 Recommendation Errors



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National Agent E&O Claims Frequency - Top 5 Risk Assessment Errors



- ✓ Failure to adequately identify value of the exposure and recommend adequate limits

Big “I” Advantage Products and Services – Insurance Markets

RLI Personal Umbrella Policy:

Your agency can reduce exposure to E&O claims by offering increased limits, especially on all of your personal lines customers. Big “I” members can access RLI Personal Umbrella Policy with no volume requirements. RLI's PUP stands atop your existing homeowner and auto insurance to provide an extra layer of personal liability protection for you and your family. With RLI's PUP program, you can maintain your auto or home coverage with whatever insurance company you choose, provided you agree to maintain the mandatory minimum underlying coverage limits. Visit www.independentagent.com/RLI for more information.

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- ✓ Errors on proposals
- ✓ Overstating the benefits provided by an insurance policy or the services offered by an agency

What the Producer Can Do

At this stage of the customer life cycle, producers are far more involved with the potential customer than are other agency staff members.

The Best Practices for avoiding E&O losses at this stage are:

- ✓ If you prepare your own marketing or advertising materials, be sure they don't over promise benefits of policies or services to be provided—have them reviewed and approved by an agency principal
- ✓ Avoid using terms such as “all risk”, “full coverage”, or “comprehensive” as they tend to imply that coverage is broader than is actually the case
- ✓ Do not hold yourself out to be a risk manager if you are not qualified to do so
- ✓ Stay within your areas of expertise – in terms of coverage and types of accounts - E&O claims often happen when a producer ventures into unfamiliar waters
- ✓ Use a checklist or formal fact-finding tool to gather underwriting information
- ✓ Talk to the right person—the owner of the business is not necessarily the person in possession of the information you will need to provide a quote
- ✓ Confirm all preliminary conversation with the prospect in writing as soon after the conversation as possible and document the file accordingly
- ✓ Document if there were any areas of a prospect's operations that were not reviewed and indicate the specific reason (e.g., the insured did not wish to have a particular area or entity reviewed) and include it in the file
- ✓ Include appropriate disclaimer language on all proposals
- ✓ Provide sufficient detail so the prospect understands what is being proposed

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- ✓ Identify any necessary steps the applicant must take before coverage can be put in effect, such as supplemental applications, loss control recommendations, etc. and notify them of that, preferably in a written form, and document the file accordingly
- ✓ Include coverage options and the cost of those options in all proposals, even if they are “indications” rather than firm quotes
- ✓ Recommend important coverages, such as EPLI, Flood, etc. and propose higher limits when appropriate, including an estimated cost of each, and document the file accordingly

Big “I” Advantage Products and Services – Insurance Markets

Big “I” Markets:

Big “I” members have exclusive access to Big “I” Markets which can provide access to important coverages to help you meet your customers, in turn reducing the chance of an E&O claim. Big “I” Markets provides access to high quality insurance products with no access or volume requirements. Each product on Big “I” Markets includes detailed underwriting guidelines and streamlined applications and your agency interacts directly with the product provider. Visit www.bigimarkets.com to learn more about offering products that can help your agency avoid potential E&O claims by meeting your customers’ insurance needs.

Big “I” Advantage Products and Services – Insurance Markets

Big “I” National Flood Program:

Offering flood insurance to every customer may reduce your agencies E&O exposure. Big “I” members have access to the Big “I” National Flood Program and the underwriting carrier, Selective Insurance Company. Flooding can occur at any time of year, and can result from many different types of meteorological events—not just rain. And it is not only important for independent agents to recognize the need for flood insurance, it is important that consumers understand the importance of flood insurance as well. Visit www.independentagent.com/flood to learn more about accessing this valuable coverage.

- ✓ Do not make coverage decisions on behalf of the prospect
- ✓ Have the prospect initial or sign off on any recommended coverage that is being rejected and maintain that for the file. If the insured will not sign off on the declination send them a certified letter with an understanding that coverage was offered but declined.
- ✓ Advise prospects in writing whenever coverage cannot be placed, what the reason is, and what the process is for placing coverage in the future
- ✓ Confirm in writing whenever a proposal is rejected and include a reminder that no coverage has been provided
- ✓ Include an expiration date or time limit on all quotes and proposals

What the CSR Can Do

On smaller commercial or personal lines accounts, it is not unusual for the sales process to be handled by a CSR or other internal sales associate. On larger accounts, the CSR often works in conjunction with the producer to prepare applications, submissions, and proposals. The Best Practices for the CSR in Marketing and Selling are:

- ✓ Double check any applications being submitted to carriers to ensure all required information has been provided—contact the producer and/or your supervisor if

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items have been omitted, since you can be the last line of defense to preventing an E&O claim.

- ✓ Ensure that you are using the agency's standard proposal form and that it includes an appropriate disclaimer
- ✓ Whenever possible, transmit the insurer's quote to the prospect, rather than re-entering information and document the transmission for the file (such as surplus lines or small business transactions)
- ✓ When requesting a prospect's signature on an application, ask that they also initial each page of the application
- ✓ Prepare agency form letters to advise a prospect what may be required in order to put coverage into effect, such as signed applications, financial statements, or loss runs and document the file accordingly
- ✓ Notify potential customers in writing as soon as you become aware of any problem in placing coverage and document the file
- ✓ Document both coverage placed and any coverage rejections by a confirming letter and maintain a copy for the file
- ✓ Confirm in writing whenever a proposal or quote is rejected and include a reminder that no coverage has been provided and document your file accordingly
- ✓ If a policy is issued, verify the coverage against the applications, binder and proposal and if it does not match, follow-up with the producer or in accordance with other agency procedures

What Management Can Do

Ultimately, the responsibility for everything that occurs in the agency rests with the owners and managers. Best Practices for the agency's leaders in Marketing and Selling are:

- ✓ Review all advertising and marketing materials used on an ongoing basis to ensure they are up to date and accurate; this may be best accomplished if calendared for a set date several times a year
- ✓ Provide tools and resources to producers and CSR's, including exposure checklists and questionnaires, to assist them in performing account reviews
- ✓ Provide guidance on what types of new accounts the agency is seeking

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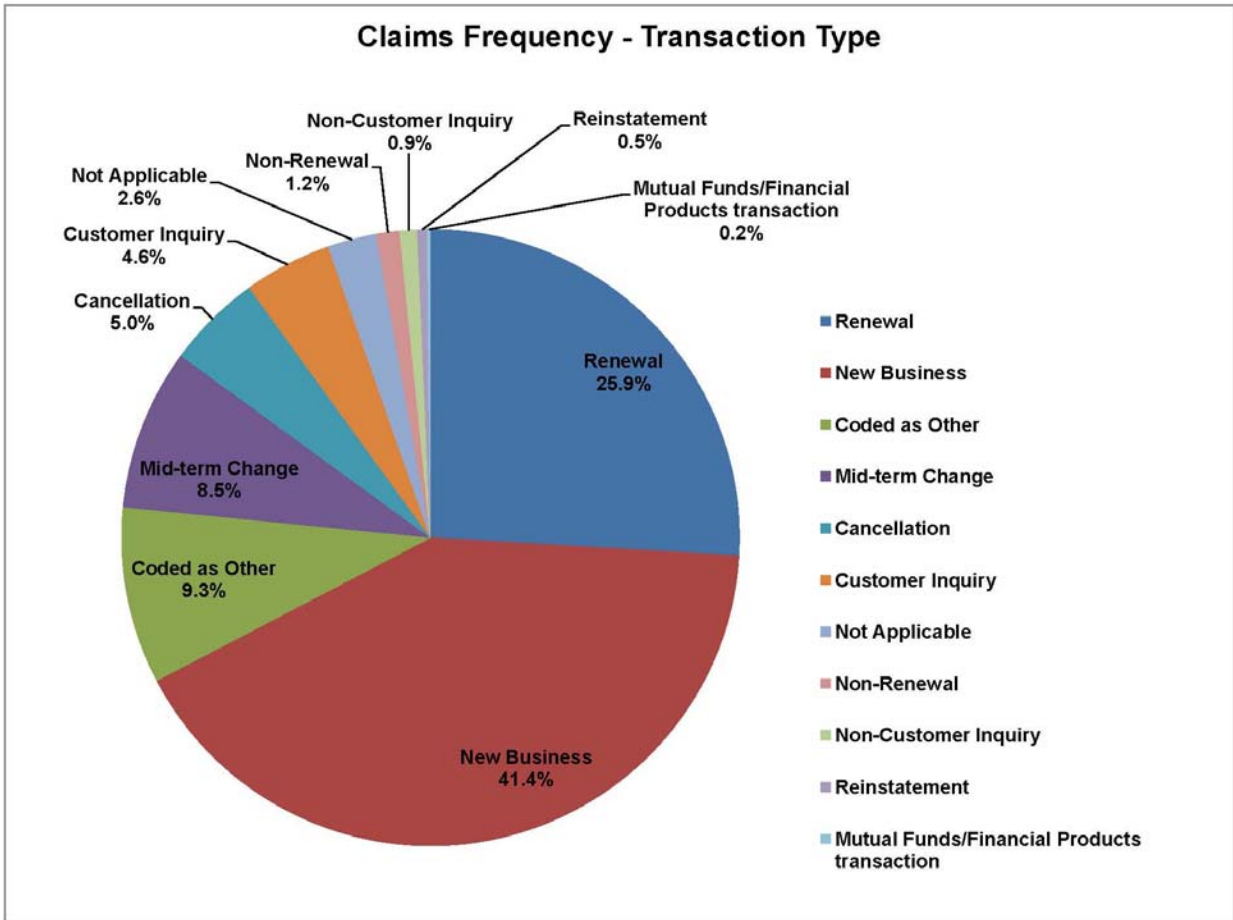
- ✓ Develop and adhere to a written procedure for marketing and selling the agency's products and services
- ✓ Remain available to assist with questions and problems as they arise so they can be addressed in a timely manner
- ✓ Keep agency exposure to E&O claims at the forefront of your producers and CSR's minds by having them take a yearly E&O class

New Business

Many agencies rely heavily on the new business from current agency customers because of the opportunity it provides to demonstrate true "value added" to the agency's customers. However, new business transactions, as demonstrated by the data, are also an area of concern for E&O purposes. One of the most important loss control tools for the agency is completion of a risk analysis checklist and a thorough review of a prospect's loss exposure.

National Claims Statistic: Claims involving new business transactions are the largest driver of E&O claims, with approximately 42% of all claims coming from the new business transactions. Renewal transactions cause the second highest frequency of claims at about 27%. New business claims can be broken down further into claims from new customers and claims for placing a new coverage for an existing customer at 22% and 20% respectively. The new business procedures are an important place to focus on to eliminate potential E&O claims.

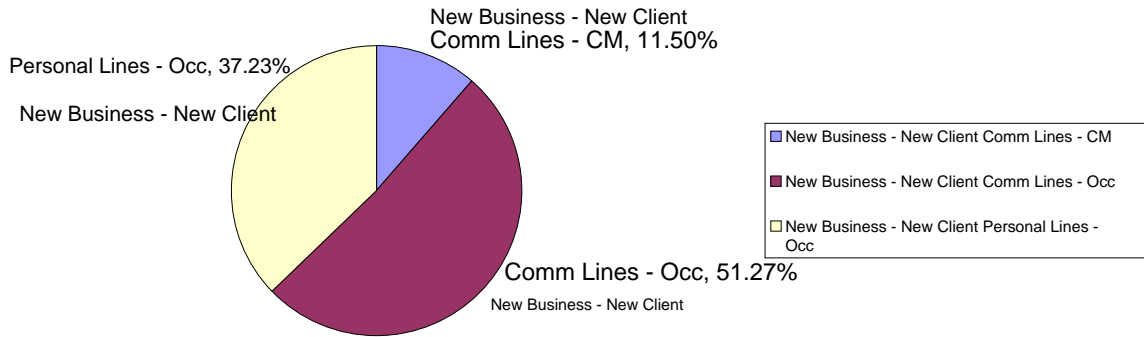
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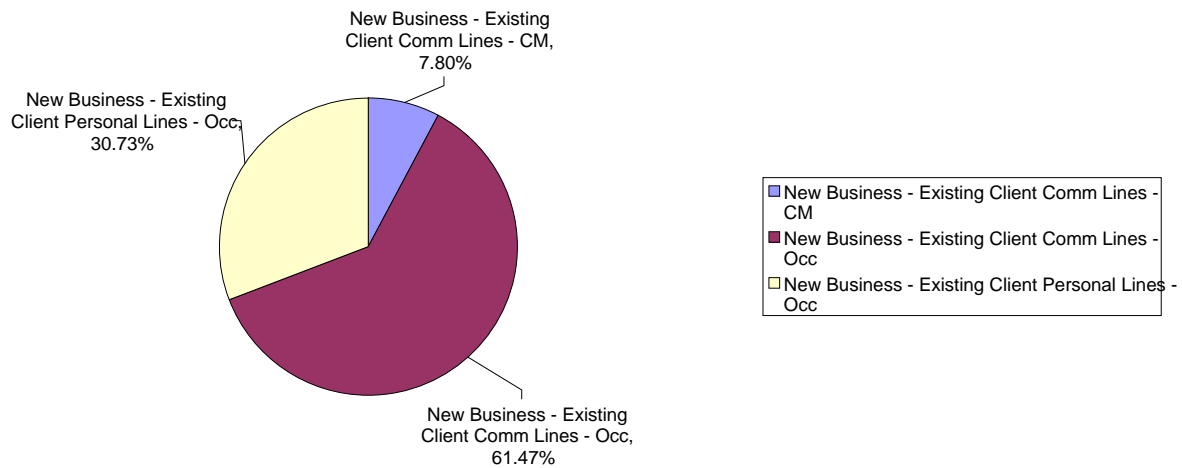
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National Agent E&O Claims Frequency - New Business - New Client by Type of Policy



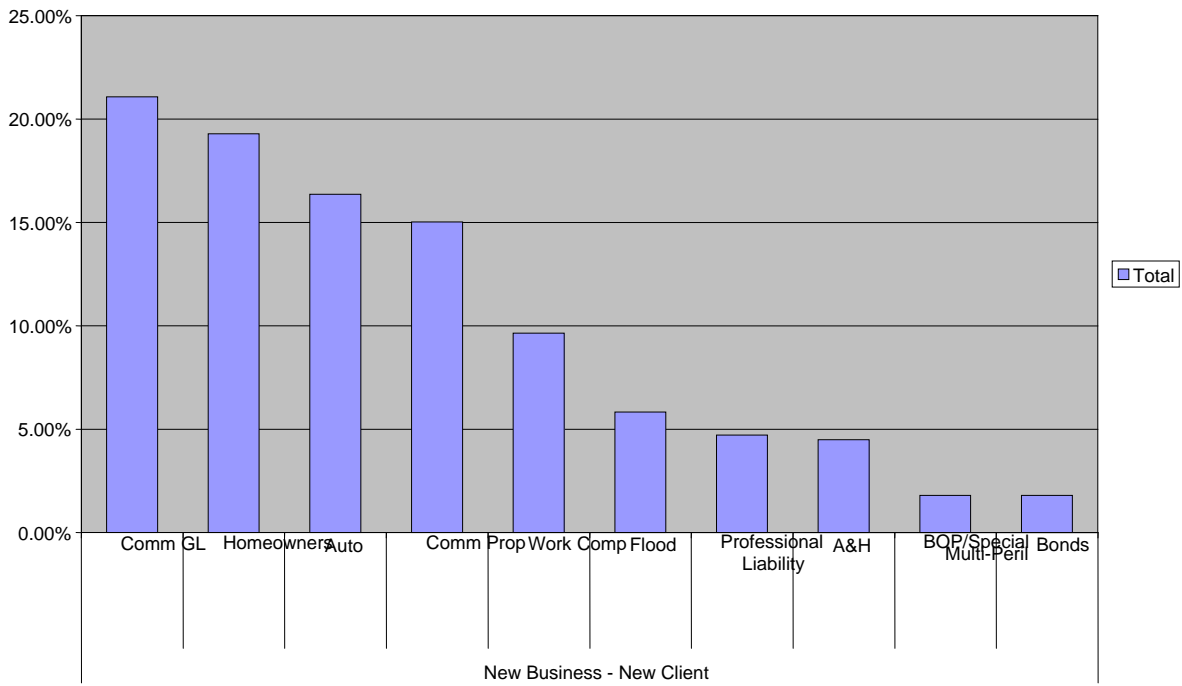
National Agent E&O Claims Frequency - New Business - Existing Client by Type of Policy



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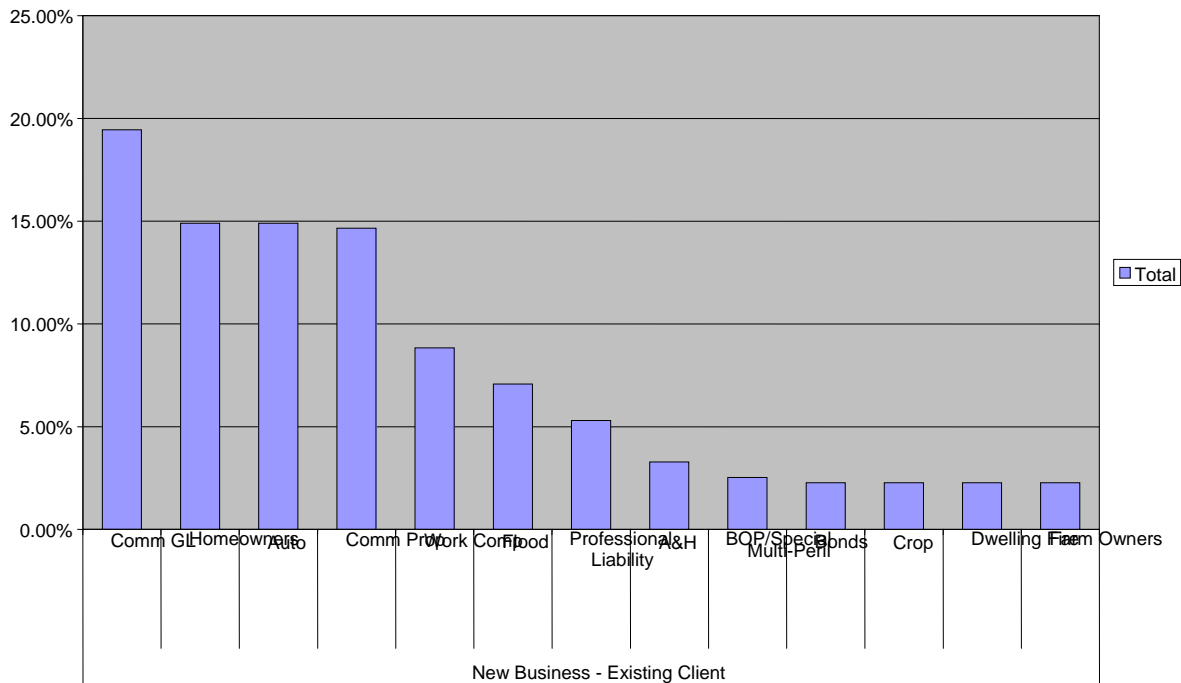
National Agent E&O Claims Frequency - Top 10 New Business - New Client by Underlying Coverage



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National Agent E&O Claims Frequency - Top 10 New Business - Existing Clients by Underlying Coverage



Types of Typical E&O Claims

- ✓ Failure to process applications in an accurate and timely manner
- ✓ Failure to procure the coverage requested by the prospect/customer
- ✓ Failure to adequately identify exposures including advising the customer of any coverage gaps, limitations, or restrictions
- ✓ Failure to obtain, add or accurately identify additional insureds or loss payees
- ✓ Failure to advise the insurer in a timely manner when coverage was bound by the agency on its behalf

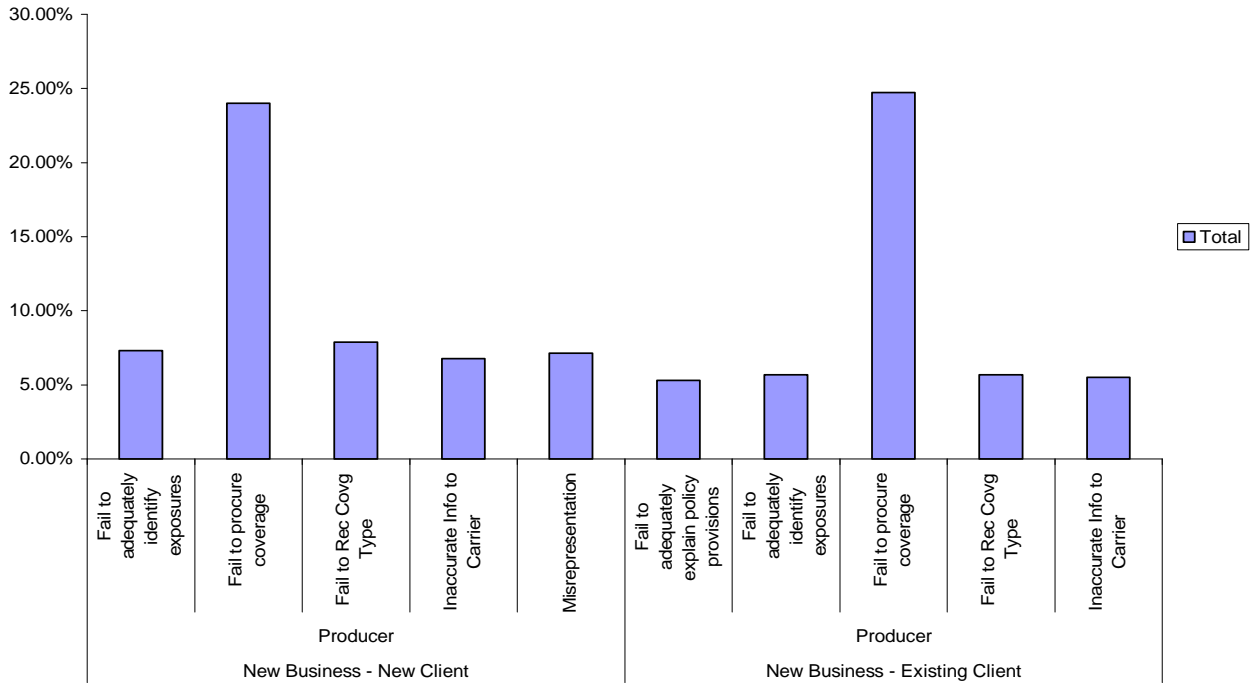
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National Claims Statistic: The person most often involved in new business claims is the producer at about 37% of claims, followed by licensed CSR's (25%) and account managers (21%).

What the Producer Can Do

As a general practice, many agencies do not want producers to complete applications in the agency management system. This is best done by the CSR. Producers are, however, responsible for gathering all necessary underwriting information and transferring it to the person who will be completing the applications in the agency management system. Here is a closer look at new business errors made by producers and what can be done to prevent E&O claims for the agency.

National Agent E&O Claims Frequency - Top Five New Business Errors by Producers (Jan. '04 to Dec. '06)



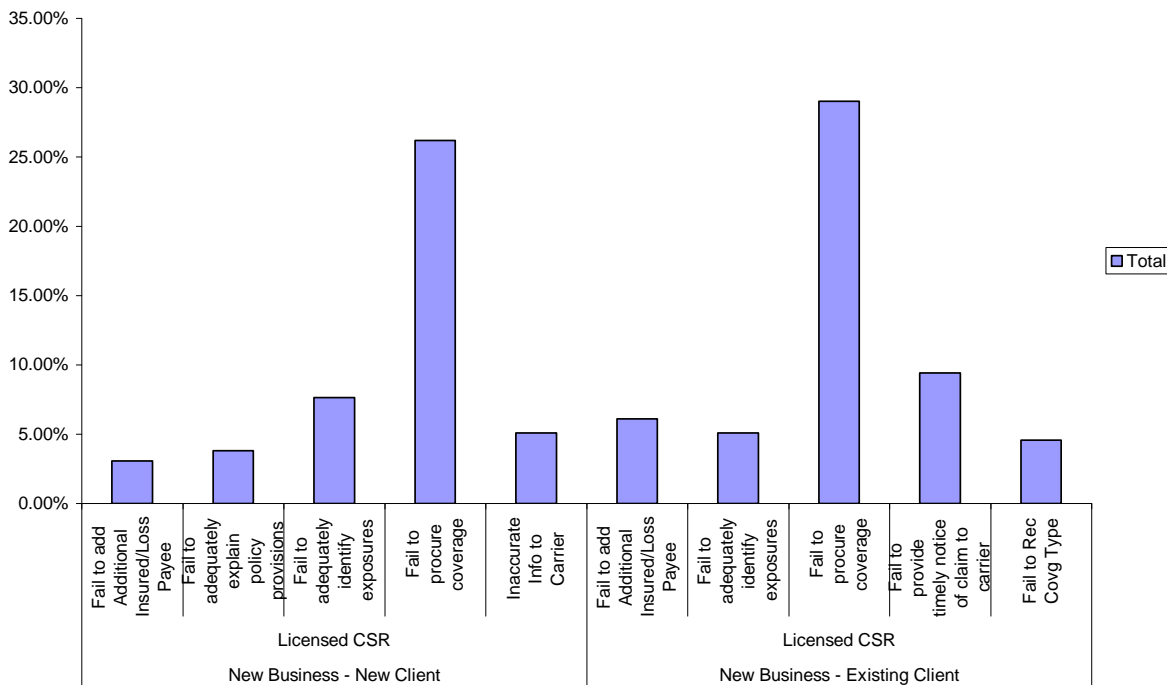
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- ✓ USE A CHECKLIST!
- ✓ Create a comprehensive narrative of each customer's circumstances based on the initial meeting or conversation with the customer for the file
- ✓ Advise customers who will be handling their account on a daily basis and make an introduction (by mail or in person) as soon as possible
- ✓ Meet with the CSR who will be handling the account and acquaint them with it and ask them for their thorough review of the account as a "second set of eyes" that might prevent something being overlooked
- ✓ Confirm in writing all coverages that have been arranged—and those that have not at the insured request. Have the prospect initial or sign off on any recommended coverage that is being rejected and maintain that for the file. If the insured will not sign off on the declination send them a certified letter with an understanding that coverage was offered but declined.
- ✓ Deliver policies to the insured within a standard timeframe from when they are received on your desk—if this cannot be done, return them to the CSR to mail and make an appointment to see the customer at another time
- ✓ Document for the file all attempts to deliver a policy
- ✓ If delivering policies in person, review the policies themselves with the insured, and do not rely on coverage summaries or other synopses of coverage in place
- ✓ Point out any important or unusual exclusions, restrictions or limitations contained in the policies being delivered, and confirm them in writing in a cover letter to the insured—this should correspond to what was contained in the proposal and keep a copy in the file
- ✓ If the insured has any duties under the policy (e.g., filing police reports, preserving and protecting property, etc.) let them know since compliance with policy provisions is a condition of coverage

What the CSR Can Do

A CSR's responsibility for a piece of new business usually begins when he or she meets with the producer to discuss the account and how and to whom it will be marketed. At that point, applications are prepared in the agency's management system. The importance of complete, accurate applications cannot be overstated since it ensures that obligations to the insurance company are met while at the same time getting the best price for the insured. About 25% of claims from new business transactions involve the CSR, which is second only to producers. Here are the types of claims made by CSRs in the new business process.

**National Agent E&O Claims Frequency - Top Five New Business Errors by Licensed CSRs
(Jan. '04 to Dec. '06)**



- ✓ Transmit to the carrier all completed applications for coverage the business day they are received in the agency
- ✓ Confirm in writing to the insured any time an application cannot be processed and what is required in order to put coverage in effect (e.g., money or finance agreement, MVR, loss runs, etc.)

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- ✓ Have the insured sign all applications and initial each page, making sure the customer is instructed to review every question on the application, not just those that are “highlighted”
- ✓ Document all coverage rejections by sending a confirming letter and document the file accordingly
- ✓ Prepare binders or request them, as appropriate, the same day coverage is ordered
- ✓ Obtain prior approval from the company if in doubt of your authority to bind coverage
- ✓ Get an assigned policy number from the insurer whenever coverage is ordered
- ✓ Do not reiterate policy language on a binder
- ✓ Create a suspense for receipt of the policy from the company
- ✓ Cancel any binders if it is determined that the insured does not wish to continue coverage and seek confirmation of that in writing when possible, or confirm it with the customer in writing, and invoice the insured for any earned premium and of course document the file
- ✓ When the policy is received, verify it against the application, binder and any other correspondence that may have taken place since the policy was ordered to be sure it is accurate, and if not, follow-up with the producer or as otherwise required by agency procedures
- ✓ Include a transmittal letter for all policies sent or delivered to an insured and document the file accordingly

What Management Can Do

- ✓ Determine which companies have the most restrictive agency appointment contracts in terms of time to complete specific transactions and use the time period in those contracts as a target for all transactions (e.g. required time frames for submission of applications notice of claims, binding limitations, or exceptions, etc.)
- ✓ Communicate to all employees involved in processing the application the time frames for transmittal of new applications to carriers and the agency’s binding authority with each company. Periodically review files to make sure time frames are adhered to

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- ✓ Create a matrix that details all the binding requirements and restrictions for each carrier, and update it periodically—it can be placed on a shared drive for easy access of the most current version
- ✓ Determine who within the agency has binding authority and clearly communicate that with all staff handling customer needs—in some cases, this is granted only to specific individuals. Consider creating a list with each company's binding authority and periodically review
- ✓ Determine if any laws or regulations in your state limit the number of days for which a binder may be issued, and if so, be sure to adhere to that, even if a company appointment contract allows for a longer time period
- ✓ Run a report to determine if binders issued have been replaced by policies within the prescribed time frame, and if not, follow-up to correct the deficiencies identified
- ✓ Research the financial standing of any insurance company with whom business is placed, making sure the A.M. Best rating complies with any requirements of the agency's E&O carrier
- ✓ Prepare a written procedure for handling new business transactions

Endorsements (Policy Changes)

Few things in the insurance business are static, and therefore we often have to make changes to policies as the insured's circumstances change or to correct errors that were made when issuing a policy.

There are only three kinds of changes that can be made to a policy, and each has its unique set of E&O issues:

- ✓ Coverage can be added or increased
- ✓ Coverage can be deleted or reduced
- ✓ Coverage can be modified

The E&O consequence of adding or increasing coverage when it is not desired by the insured is a small one—the premium paid by the insured will be higher than it otherwise would be. Using a risk management approach, in these circumstances the largest loss the agency could suffer, would be to pay any earned premium for coverage not requested or desired by the insured.

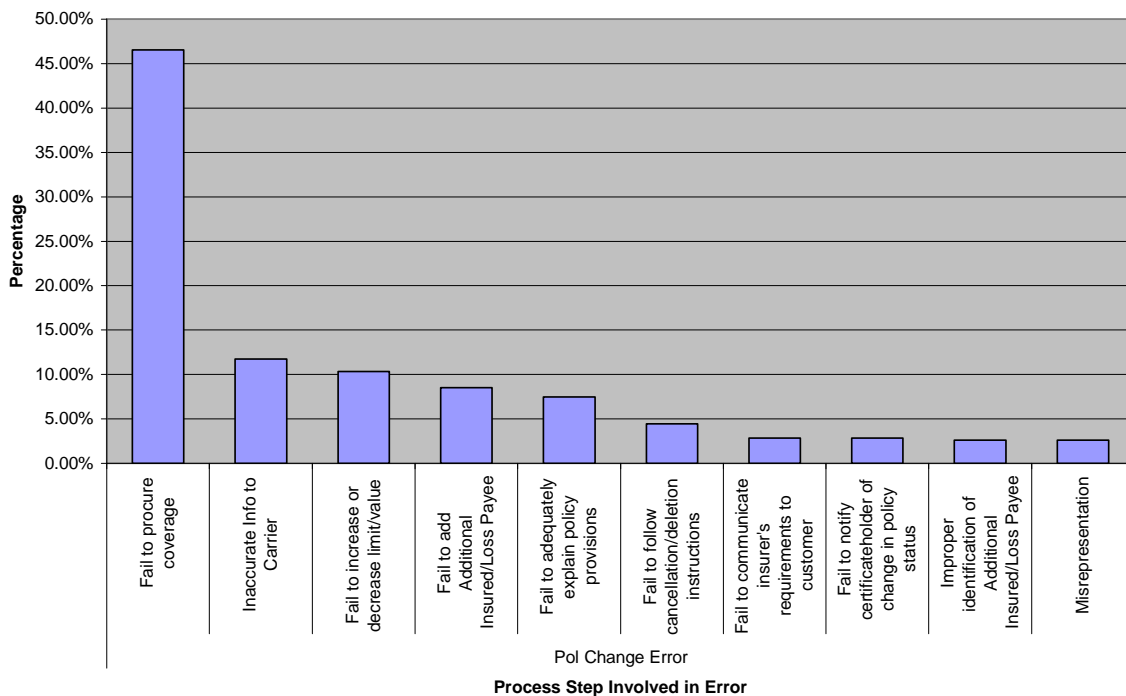
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When we fail to increase or add coverage as requested, on the other hand, the potential loss to the agency is the amount of coverage that should have been in place, which could be substantial. In fact, it could exceed the agency's E&O policy limit!

National Claims Statistic: About 10% of all claims are made during the policy change process step. Contrary to what you would expect about 40% of those claims come from producers, followed by CSR's at 25% and account managers at 15%. This may be an indication that producers were performing a task that was best handled by the CSR.

National Agent E&O Claims Frequency - Top 10 Policy Change Errors (Jan. '04 to Dec. '06)



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Types of Typical E&O Claims

- ✓ Failure to procure coverage by endorsing all policies when requested to make a change
- ✓ Providing inaccurate information to the carrier
- ✓ Failure to increase or decrease limits or add coverage in a timely manner
- ✓ Failure to identify or add an additional insured/loss payee
- ✓ Making a policy change based on an unauthorized instruction (such as from a person without authority to give the instruction)
- ✓ Failure to endorse all policies when requested to make a change

What the Producer Can Do

The responsibility for handling routine transactions on a policy once issued typically lies with the CSR. If that is the procedure in your office, then producers have only limited accountabilities when it comes to making policy changes:

- ✓ If a customer calls to make a policy change, immediately transfer the call to the appropriate CSR
- ✓ If it is not possible to transfer the call to the CSR, either have a CSR return the call to the customer immediately, or take the necessary information and transmit it promptly to the CSR for handling via e-mail so the request can be attached to the customer file or documented in the agency management system with a suspense assigned to the CSR

What the CSR Can Do

- ✓ Handle the request for a policy change by entering the information in the agency's management system and transmitting the Policy Change Request to the company while you still have the customer on the phone
- ✓ Confirm all policy changes with the insured in writing and document the file accordingly

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- ✓ Confirm all changes with the named insured, preferably in writing, with a copy to the file—do not act on the instruction of a third party (mortgage company, auto dealer, etc.)
- ✓ If you are asked to delete or reduce coverage, advise the insured of the consequences of such changes, and propose other options, if appropriate, and document the file accordingly
- ✓ Require the insured to make requests for reductions or deletions in writing, via mail, fax or e-mail and include the request in the file
- ✓ Be sure to make changes to all policies to which that change might apply
- ✓ When the endorsement is received, check against the documentation in the customer's file, including the Policy Change Request, and if it is not accurate follow-up to get it corrected

What Management Can Do

- ✓ Provide ergonomic work stations and headsets for service staff members that support easy access to the agency's database and allow them to handle transactions while on the phone with customers
- ✓ Encourage the use of "rotational" servicing, so no customer request is delayed until a particular CSR is available
- ✓ Prepare written procedures for handling endorsements and policy changes

Claims

The fastest way to alienate a customer is to mishandle a claim. Until a loss happens, the only thing the customer has received from us is a promise. Claims are our way of delivering on that promise. Although the agency is not as involved with claim handling as the insurance company, it is a value added opportunity for the agency to assist their customer in helping manage the expectations of the claims process.

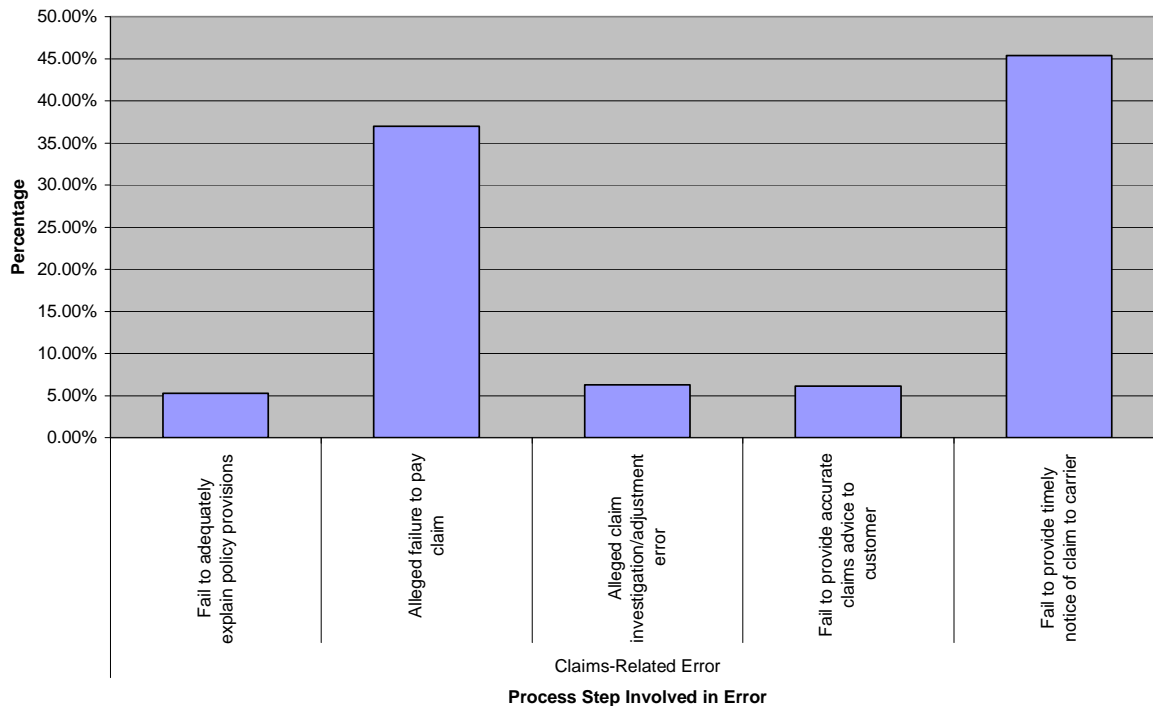
In many agencies, CSRs are responsible for handling claims for the customers assigned to them. Other agencies have a separate claims department. Regardless of who handles the function in the agency, the procedures are the same.

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National Claims Statistic: Next to the recommendation process step of the transaction, the claims-related errors process step is seen most frequently at almost 13%. Like policy change data, it is interesting to see that almost 40% of the claims-related process step errors come from producers. Should producers really be involved in the claims reporting process? Licensed CSR's make up 26% of claims-related errors and account managers about 14%. Remember in many cases the customer's unpaid claim can be the event that leads to a potential E&O claim.

National Agent E&O Claims Frequency - Top 5 Claims-Related Errors (Jan. '04 to Dec. '06)



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Types of Typical E&O Claims

- ✓ Failure to provide timely notice of a claim to the carrier
- ✓ Failure to transmit a lawsuit to the carrier in a timely manner, resulting in a default judgment against the insured
- ✓ Failure to notify an insurance carrier when other coverage (or a defense) might be provided by another carrier or party
- ✓ Alleged claim investigation/adjustment error (e.g. - Giving authorization to an insured to make repairs prior to approval by the insurer)
- ✓ Failure to adequately explain policy provisions or misleading an insured to believe coverage will be provided when it will not

What the Producer Can Do

- ✓ When delivering policies, advise the customer to report any losses to their CSR or a claims associate in accordance with the provisions of their policy, and consider including this in the cover letter or an accompanying instruction sheet and document the file
- ✓ For routine losses, turn the customer over to the CSR or other appropriate agency personnel immediately for handling and communicate with the insured so they know who to contact for assistance. Create suspense to follow-up with the CSR to make sure the customer's needs were handled.
- ✓ On very large losses, consider monitoring the progress of the claim for the customer and remain available for questions, but allow the insurance company and others in the agency to handle the matter

What the CSR Can Do

- ✓ Treat all claims as critical—they should generally be handled the same business day they are received
- ✓ Manage the expectations of the policyholder—advise them of the time frame when they should be contacted by an adjuster

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- ✓ If the insured has any duties under the policy (e.g., filing police reports, preserving and protecting property, etc.) let them know since compliance with policy provisions is a condition of coverage, and document the file accordingly
- ✓ Encourage the customer to contact you if they have not heard from the insurance company in a reasonable period of time
- ✓ Follow up with the customer within 72 hours to determine if contact has been made with them by the carrier
- ✓ Don't affirm or deny coverage—that's the insurance company's responsibility
- ✓ Be sure to put on notice any carriers who MIGHT provide a defense or coverage, especially for liability situations
- ✓ Notify any excess or umbrella carrier immediately if the loss appears to be one that will trigger coverage, such as a very large and/or serious loss, such as a fatality, loss of limb, etc.
- ✓ Don't advise the insured who to hire to make repairs
- ✓ Report all claims to the insurer that are reported to you—explain to the insured the importance of timely reporting to protect their interest
- ✓ If a loss will be less than the insured's deductible, advise them so they may make arrangements to pay for the PROPERTY loss themselves, although this is not advisable to do for even small LIABILITY claims
- ✓ Look for trends in losses on particular accounts, and advise the producer or CSR if a trend or pattern is apparent

What Management Can Do

- ✓ Monitor claims activity for the agency to ensure the necessary follow up with carriers is taking place and that insureds are appropriately contacted as well
- ✓ Monitor claims activity by carrier to spot deteriorating loss ratios, assess patterns or common claims, and determine if the agency can assist customers by referring them to resources to help them reduce claims
- ✓ Provide increased education for lines of business with loss ratios trending upward, since the increase in claims means that loss control measures should be enacted

- ✓ Prepare a disaster plan for your agency so that in the event of a widespread claim situation, such as occurs after a flood, hurricane, or tornado, other natural or even a man-made disaster, you can be back up and running and serving your customers

Big “I” Member Benefit:

Key Considerations in Disaster Planning and Management

At no cost to members the Agents Council for Technology (ACT) has developed this checklist to reflect the lessons learned from recent disasters and is applicable to every agency. It emphasizes systems, telecommunications, and people issues.

The critical things are for the agency or brokerage firm to think through how it will manage the disaster *in advance*, and to develop a continuity plan where its employees understand their role in the emergency, and regularly practice responding to the various contingencies. This report focuses on the key, strategic issues agents need to be aware of and take action on to implement an effective disaster plan. In addition, agents will find the catastrophe planning tools available on the market to be very helpful as they structure their plans. Visit the www.independentagent.com/ACT to learn more.

- ✓ Establish a written procedure for claim handling and train your staff on it, as appropriate
- ✓

Renewals

Typically, it is the insurance company’s legal responsibility to provide a renewal policy to an insured, unless they have discharged their legal duty to notify the customer of non-renewal. Since this responsibility is generally not that of the agency, and because many policies are forwarded directly to the insured without going first to the agency, it is easy to become complacent in the renewal process.

Every customer, regardless of size or line of business, generally appreciates being contacted at least annually to determine if there have been any changes that will impact their insurance

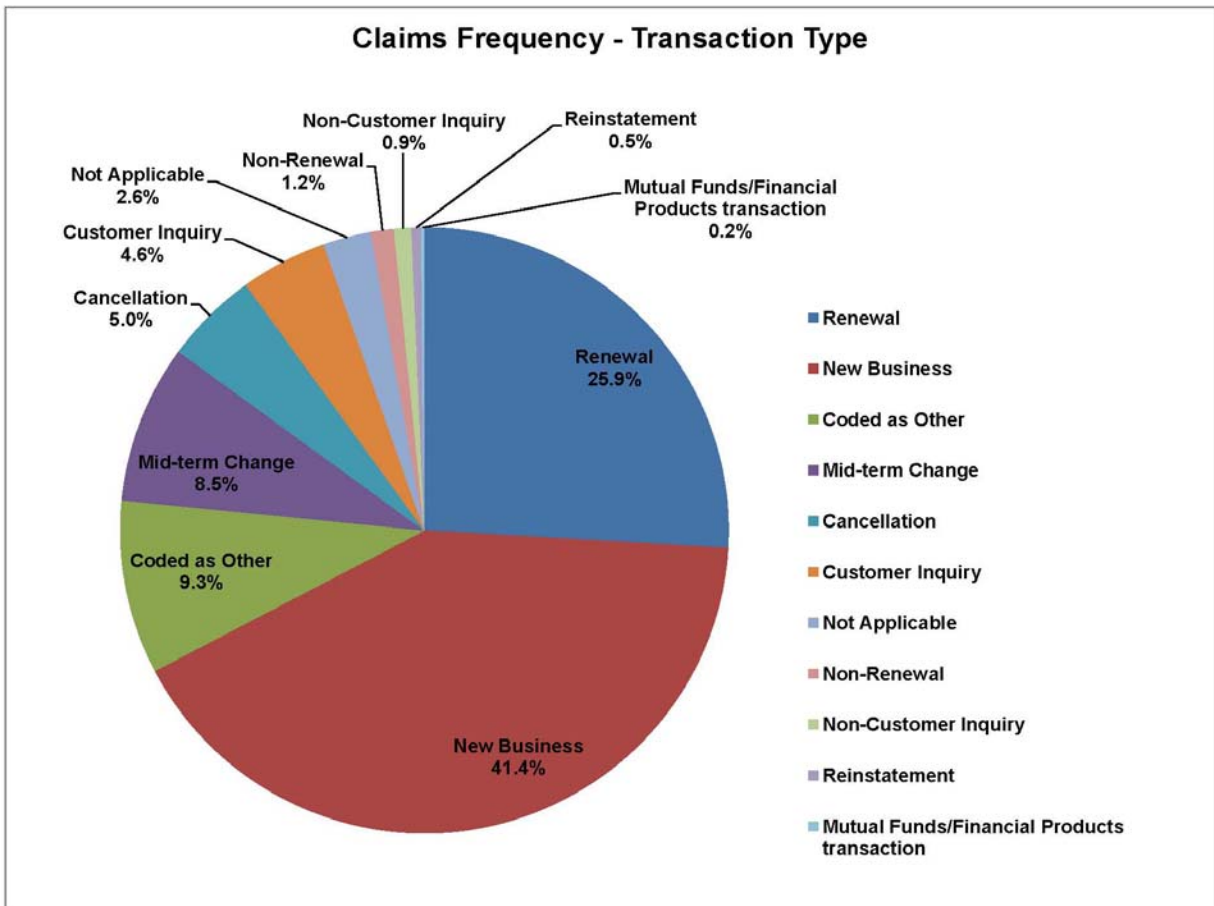
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coverages. This personal “touch” can be a visit, a phone call, an e-mail, or a form letter and provides a perfect opportunity for the agency to round out accounts and reduce E&O exposures.

Direct bill policies, although transmitted to the insured by the company, should receive the same attention from the agency as agency bill renewals receive. Likewise, any policies the agency receives from the carrier in a download still require that the agency contact the insured to determine any changes that may be in order.

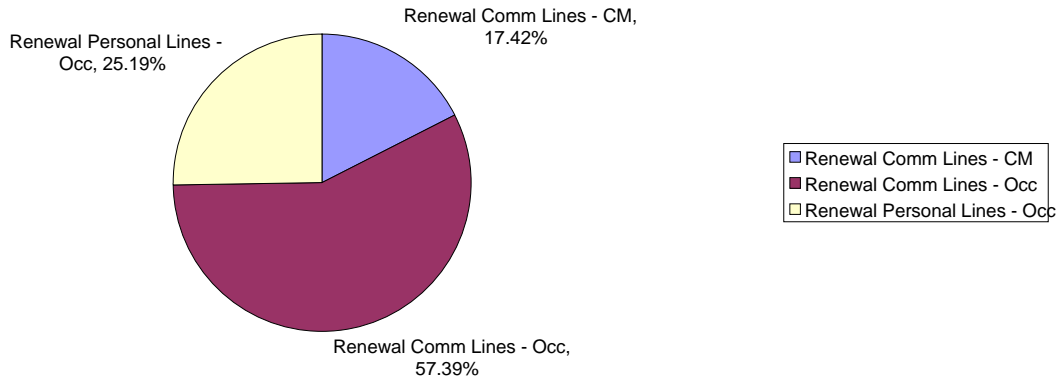
Very large accounts are often heavily marketed at renewal. As such, the process really is the same as when the account was new to the agency, and the proper procedure to follow would be that for new business.

National Claims Statistic: Claims involving renewal transactions are the second largest driver of E&O claims (second to new business transactions), with approximately 27% of all claims coming from the new business transactions.



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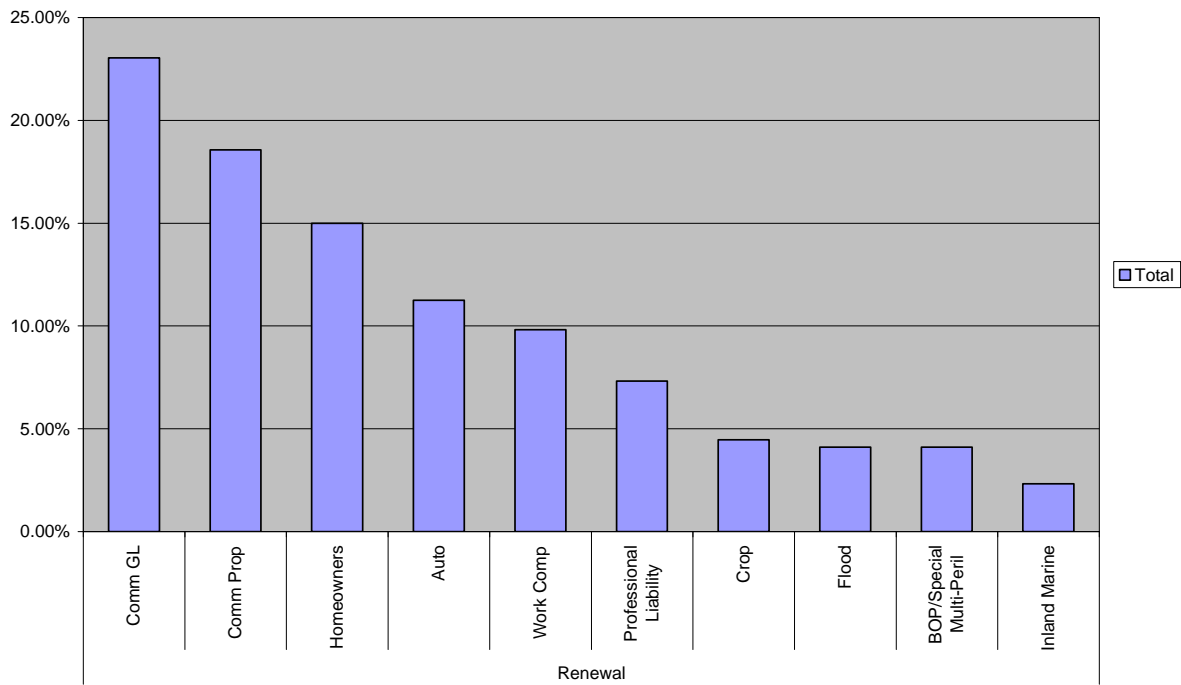
National Agent E&O Claims Frequency - Renewal Errors by Type of Policy



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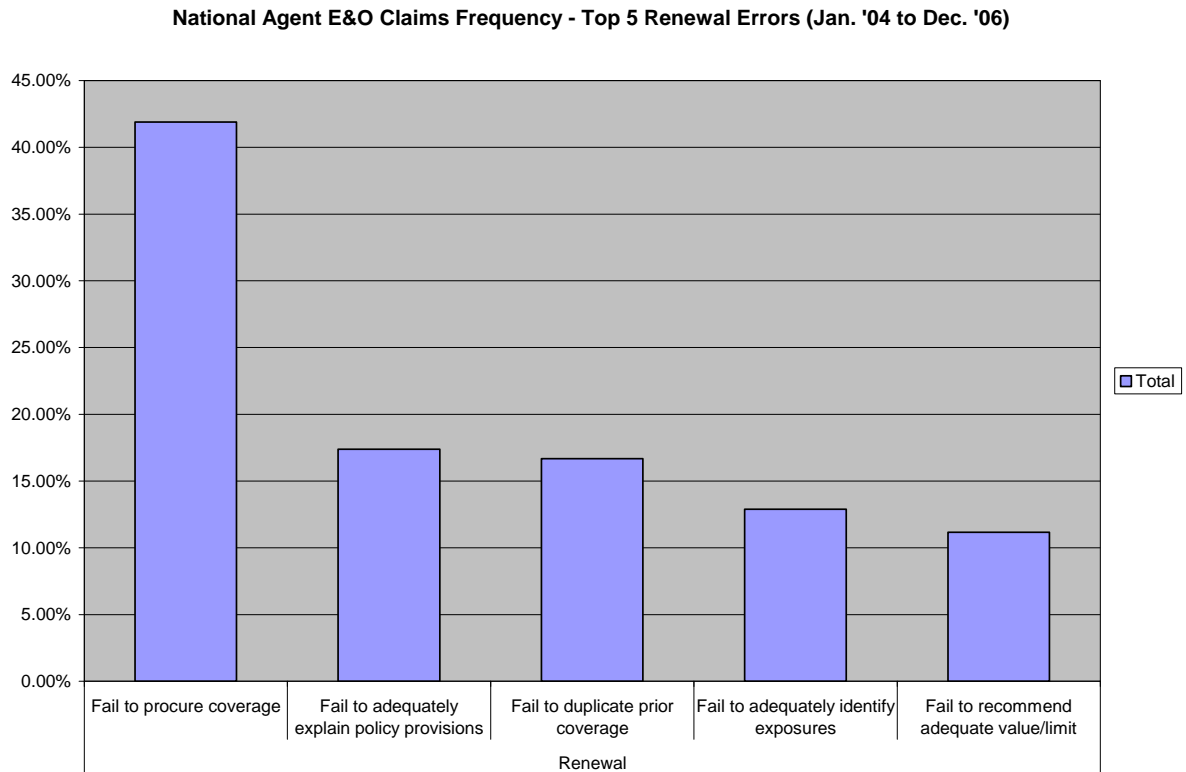
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National Agent E&O Claims Frequency - Top 10 Renewals by Underlying Coverage (Jan. '04 to Dec. '06)



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Types of Typical E&O Claims



About one-fourth of E&O claims involve a renewal. Specifically, the situations that give rise to E&O claims involving renewals typically include:

- ✓ Failure to procure a renewal policy
- ✓ Failure to duplicate prior coverage
- ✓ Failure to adequately identify and secure coverage for new exposures
- ✓ Failure to recommend adequate value/limit
- ✓ Errors when entering information on renewal applications
- ✓ Failure to adequately explain to the insured policy provisions or what must be done to secure a renewal

What the Producer Can Do

On smaller accounts or those that are automatically renewed by the carrier, there is usually limited producer involvement. If, however, a producer is involved with the renewal process, the following steps should be taken:

- ✓ USE A CHECKLIST!
- ✓ Contact the customer to set an appointment to review their account, typically approximately 90 days prior to the renewal date
- ✓ Advise the customer how the renewal process will work
- ✓ Determine with the customer if the account will be marketed to other carriers, or if it is best to negotiate with only the current insurer
- ✓ Consider offering increased limits option with every renewal
- ✓ Be sure to include any previous coverage recommendations when transmitting the renewal quote or proposal (or at original policy inception specify in writing that you will not be offering original recommendations unless requested by the insured), and obtain any rejections in writing and document the file accordingly
- ✓ Assist the CSR in preparing a renewal submission, if appropriate
- ✓ Review renewal quotes and prepare presentation to the insured
- ✓ Make the renewal presentation to the customer

What the CSR Can Do

The agency service staff is primarily responsible for seeing that all business is renewed prior to its expiration date. If a producer is involved, the CSR should meet with him or her to determine a renewal strategy.

- ✓ Run (or receive) a list of all renewals 120 days in advance
- ✓ Contact each customer by phone, mail, fax or e-mail by 90 days prior to renewal to obtain updated information and advise of the renewal process
- ✓ If applicable, obtain an updated, signed application from the insured

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- ✓ Promptly notify in writing any customer whose policy will not be renewed with sufficient time to allow them to seek other coverage, and document file accordingly
- ✓ If coverage will not be renewed by the company or your agency, advise the insured in writing and document the file accordingly
- ✓ Pay particular attention to any renewal policies placed with Excess or Surplus Lines Brokers or other non-standard markets as they require special handling and are not automatic renewals
- ✓ If coverage has been moved from one company to another, be sure all coverages, limits, deductibles and other policy terms are the same or better for the insured
- ✓ If there are any restrictions or limitations on a renewal that were not contained in the prior policy, advise the insured in writing and document the file accordingly
- ✓ Be sure to include any previous coverage recommendations when transmitting the renewal quote or proposal, and obtain any rejections in writing and document the file accordingly
- ✓ Review the expiration/renewal list once each week to make sure all renewals have been ordered prior to the expiration date, or the customer notified in writing if a renewal will not be offered

What Management Can Do

- ✓ If you've never used formal risk analysis checklists then consider implementing the use of them with new business and renewals
- ✓ Determine a plan to do an extensive review of all agency accounts every 2 or 3 years
- ✓ Prepare renewal/expiration lists at least 120 days in advance for distribution to producers and CSRs
- ✓ Stay informed on the financial status of any insurance companies with whom the agency places business
- ✓ Prepare a written procedure for handling agency bill and direct bill renewals

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- ✓ Prepare a written procedure for handling automatic and non-automatic renewals
- ✓ Prepare a written procedure for handling renewals with or without producer involvement

Cancellations and Nonrenewals

There are a variety of reasons why a policy might be cancelled mid-term or not renewed by an insurance company. These reasons include:

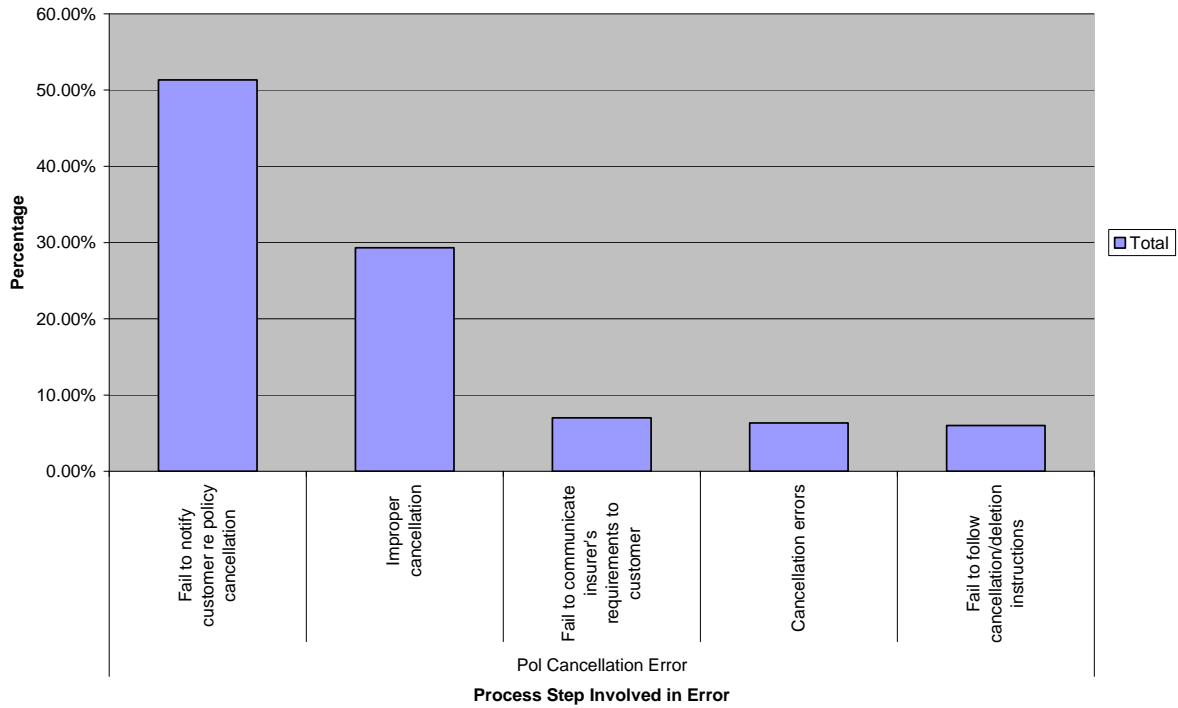
- ✓ Mid-term cancellation at the insured's request
- ✓ Mid-term cancellation at the company's discretion
- ✓ Cancellation for non-payment of premium
- ✓ Non-renewal at the company's discretion
- ✓ Non-renewal at the insured's request

Generally speaking, the insurance company must provide the number of days advance notice of cancellation or nonrenewal that is prescribed by law and the agency has no legal obligation to notify an insured when a policy is being cancelled or nonrenewed. This may vary by state law, which should always be followed. However, when there is a need to replace coverage that has been cancelled or nonrenewed, it is important to contact the customer as soon as you know and communicate to them what the process will be for replacing coverage. Replacing the coverage is ultimately the customers' decision.

One of the real problem areas for an agency is a late or bad pay account. Sooner or later, that customer may have a loss that is not covered because coverage has lapsed due to nonpayment. All customers who are written on a direct bill basis should be informed that their payments must reach the insurance company prior to the due date or they risk being uninsured. If this is not clear from the company billing or other forms, the agency can also let the customer know. It is important that producers and CSRs not insert themselves into the direct bill payment process since it could expose the agency to an E&O claim.

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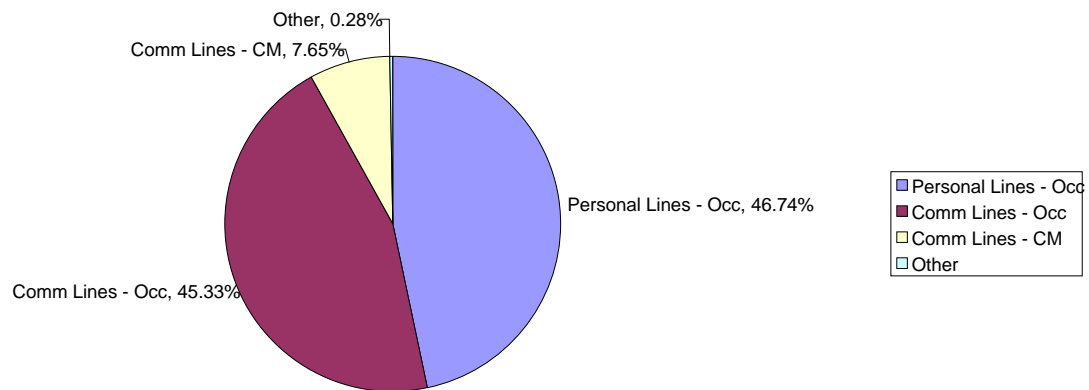
National Agent E&O Claims Frequency - Top 5 Policy Cancellation Errors (Jan. '04 to Dec. '06)



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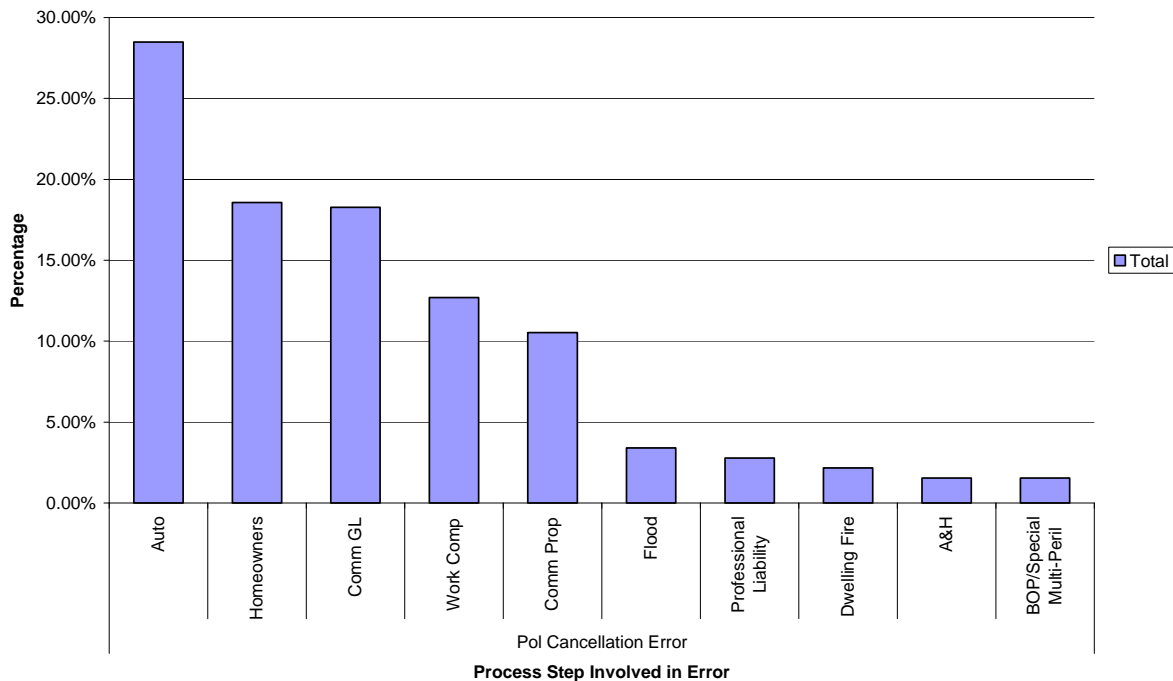
National Agent E&O Claims Frequency - Policy Cancellation Errors Type of Coverage



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**National Agent E&O Claims Frequency - Policy Cancellation Errors by Underlying Coverage
(Jan. '04 to Dec. '06)**



Types of Typical E&O Claims

- ✓ Failure to notify customer of policy cancellation
- ✓ Failure to replace coverage upon cancellation or nonrenewal
- ✓ Interfering with the insurer's right to effect cancellation
- ✓ Historically calling a customer to advise of late payments on direct bill policies and then failing to do so and a claim occurs after cancellation
- ✓ Failure to offer an Extended Reporting Period ("tail") on a Claims Made policy

What the Producer Can Do

- ✓ If coverage is to be replaced, meet with the CSR to determine what carriers to approach

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- ✓ Advise the customer if coverage can be reinstated or replaced, once that determination has been made by the carrier

What the CSR Can Do

- ✓ Avoid contacting customers who are chronically late making direct bill payments and who routinely receive a Notice of Intent to Cancel from the insurer. Consider a one-time letter to customers the first time they are late with their payment including that the agency will not notify them in the future.
- ✓ Don't commit to a customer that you can have a policy reinstated or rewritten unless you have first verified this with the carrier
- ✓ Include payment options in all proposals, including any offered by the insurance carrier or a premium finance company
- ✓ Don't interfere with the insurance company's right to advise a customer of cancellation or nonrenewal
- ✓ Preserve in the file all notices of intent to cancel that are received from a premium finance company
- ✓ If coverage is replaced with a different insurer, review all coverages, limits, deductibles and policy provisions to ensure that replacement coverage is consistent with the directives of the insured, which may be coverage the same as or broader than the prior coverage
- ✓ If there are any restrictions or limitations on the replacement policy, notify the insured in writing before coverage is placed and document the file accordingly
- ✓ If coverage was written on a Claims Made basis, inform the insured of the importance of an Extended Reporting Period ("tail") and the terms for providing one and document the file accordingly
- ✓ If an insured has cancelled a policy because they have ceased operations or gone out of business, be sure to offer discontinued products or completed operations liability if it is available and document the file accordingly

What Management Can Do

- ✓ Develop a credit policy for the agency and distribute it to all staff members regarding direct bill and agency bill practices for customers premium payments
- ✓ Don't make a practice of extending credit to customers by advancing premiums on their behalf
- ✓ Run a report of all customers who have a history of late payments to the insurance company and advise those customers who are chronically late making their direct bill payments that they must do so in a timely manner and that they will not be contacted by anyone in the agency when their payments are late after their first and only notification as mention earlier
- ✓ Advise customers that do not accept payments for direct bill policies at your office as the insured needs to and transmit them directly to the company to ensure timely receipt
- ✓ If you have had a of accepting cash payments, advise your customers that for their protection and that of your employees, you will no longer accept cash
- ✓ Establish a written procedure for handling cancellations and nonrenewals, including rules for reinstatement or rewriting of coverage

Audits

No one likes to be surprised with a large additional premium after a policy has expired. Although only a small number of E&O claims appear to be caused by post expiration audits that result in the premium due, an audit can be a source of frustration to a customer if not handled properly and can result in a bad debt to an agency.

From a process standpoint, an audit is very similar to an endorsement, however, the time frame for handling audits is much shorter and the premium is fully earned at the time the audit is issued.

Types of Typical E&O Claims

- ✓ Failure to disclose the auditable nature of a policy
- ✓ Intentionally understating or misrepresenting the premium basis at the beginning of a policy

What the Producer Can Do

- ✓ When delivering a new or renewal policy, advise the insured that the policy has been issued with an estimated premium and how the final premium will be determined in the audit and document the file
- ✓ If a large additional premium is due on an account, contact the insured to determine if there has been an error
- ✓ If the premium is owed, but cannot be paid, attempt to work out a reasonable payment plan with the insurance company

What the CSR Can Do

- ✓ When sending out new or renewal policies, advise the insured in writing that the policy has been issued with an estimated premium and how the final premium will be determined and document it in the file
- ✓ Assist the insured by informing them of recordkeeping practices that will ease the audit process and ensure its accuracy
- ✓ Get copies of the auditor's worksheets from the carrier to verify an audit (you will need the insured's consent)—nearly all audit worksheets contain errors of some kind
- ✓ Check the audit worksheets against the policy to verify rates and classifications and advise the carrier and insured of any errors or questions
- ✓ Promptly process any audit additional or return premiums
- ✓ If an audit is being disputed by the insured, determine what the company's policy is for the insured to pay any undisputed amounts
- ✓ Adhere to the company's time frame for return of uncollectible additional premiums
- ✓ Make changes to current policies based on the audited premium bases to avoid large additional or return premiums in the future

What Management Can Do

- ✓ Develop a policy for handling large additional premiums developed by an audit
- ✓ Consider setting a six month reminder letter in the agency management system to remind auditable accounts of the audit provision at the end of the policy term
- ✓ Establish a written procedure for handling policy audits and be sure staff is trained on it

THE ANATOMY OF AN E&O CLAIM

Well, the worst has happened. You have an E&O claim. What should you do?

In some cases, the agency has really made a mistake, but in others the agency is a victim of circumstance and in hindsight would have behaved the exact same way. How you react and handle the situation, however, can ultimately determine the outcome and provide a basis for changes in the agency's operations that will prevent other, similar situations in the future.

About 50% E&O claims received by E&O carriers are closed with no payment. The remaining claims are split fairly even with 50% being handled in-house by the carrier's adjusters and 50% being sent to outside counsel.

Caveats:

- ✓ Do not admit liability—to the insured or the insured's insurance company
- ✓ Be empathetic, but be careful what you say
- ✓ Do not discuss the existence of an E&O policy with anyone—and don't provide copies
- ✓ Complete a claim reporting form and forward it to your E&O carrier along with details of any conversation or correspondence you have received making a demand for damages
- ✓ Do not offer to pay the claim yourself
- ✓ Involve your E&O Improvement Specialist, or other appropriate agency personnel, and appoint a person who will be the agency's sole point of contact for all matters related to the claim
- ✓ Interview every person involved in the claim—and remember it's not about the "who", it's about the what, when, where, and how
- ✓ Have each person involved in the situation write a narrative describing the incident and check the customer's file to determine the chronology of events
- ✓ Forward all documentation to your E&O carrier
- ✓ Cooperate fully with your E&O carrier

Having an E&O claim is a traumatic event in the life of an agency. It's like walking around for a year or more with a rock in your shoe. It irritates and annoys you, and no matter how hard you try to shake it, it sticks with you.

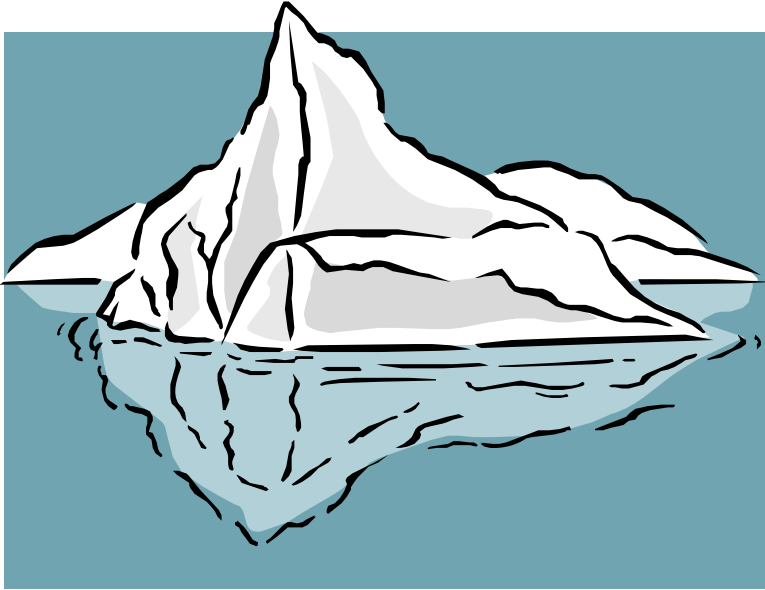
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What to Expect

- ✓ Stress
- ✓ Time lost
 - Providing a notice of loss to the E&O carrier (up to 1 day)
 - Producing documents (1 to 2 days)
 - Completing interrogatories (1 to 2 days)
 - Meeting with attorneys (2 to 3 days)
 - Giving depositions (1 day to 1 week)
 - Sitting in on witness depositions (1 day to 1 week)
 - Going to trial or participating in settlement conferences (1 to 2 weeks)

An E&O claim can consume a huge amount of time for the better part of one or two years if it goes all the way to trial. Some claims can take eight years or more to fully develop. The amount of money actually spent on deductibles and increased premiums by the agency is really just the “tip of the iceberg”. The other consequences of involvement in an E&O claim, such as public scrutiny and loss of employee morale, represent the real cost of a claim.

The Iceberg of Errors and Omissions Loss Costs



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Direct Costs

Deductible on E&O policy
Loss of the account
Loss of productive sales
and service time

Indirect Costs

Impact on agency morale
Damage to Agency Operation
Potential loss of E&O coverage
Cost of replacing lost account
Claim may not be covered by
E&O policy

Remember many agent's E&O claims involve non-coverage. Typically, the customer is alleging that you represented to them that there would be coverage for a certain situation either before or following a loss. The insurance company, however, is the final arbiter of coverage matters, and for whatever reason, they disagree. Your customer no longer remembers that you might have said "I'm not sure" or "In my opinion". All they know is that they didn't get what they thought they paid for.

Your customer has suffered a loss and in their desperation, they're looking for someone to help shoulder the financial burden. E&O claims are very fact-specific and it will take a long time to demonstrate to the customer (or a jury) that nothing you could have done would have changed the outcome for them. It's a very painful truth for them to hear.

When you are dealing with your E&O carrier, the documentation you can provide is often the difference between winning and losing. You will need to demonstrate that you had competent staff dealing with the customer, that you followed your procedures as you always do, and that

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what the customer is saying happened simply could not have taken place, because your file would reflect if it did. Legible, complete, and consistent documentation will often result in a defense verdict.

FILE DOCUMENTATION

Whether your agency operates in a totally automated environment, is still paper-based, or exists anywhere in between, file documentation is rule number one when it comes to protecting against errors and omissions losses.

Claims adjusters and defense attorneys who handle agency E&O claims all agree—there is no such thing as an over-documented file. Many E&O claims result in a version of “he said, she said” when it comes to reconstructing the conversations that took place, often many years before. No one can perfectly recall exactly what took place when handling a customer transaction, and unfortunately, in a court of law the buyer is much more likely to be believed than the seller.

It goes without saying that each and every step in the process must be documented in the customer’s file, whether electronic or paper. The file needs to tell the story of what transpired, with sufficient detail provided that anyone in the agency can read it and clearly see what took place. As is often the case, when an agency is involved in an E&O situation, not every person who was involved is still with the agency. Record-keeping is vital to defending oneself from a claim that something was done improperly or not at all.

What Constitutes Proper Documentation?

Every conversation with a prospect, customer, underwriter or other insurance company staff member, or third party (such as a person who requests a certificate of insurance or a vendor with whom the insured does business) must be recorded in the customer file. It is important to specify who initiated the call, what was the substance of the conversation, what action is to be taken, and what the next steps, if any, would be. Letters, faxes, and e-mails are less problematic from a documentation standpoint, because they actually exist and are in the words of the person who created them. They must, however be attached to the proper customer file. Form letters, ACORD forms, and other items created in an automated system will generally attach automatically to the customer’s electronic file at the conclusion of the transaction.

Who Should Document Files?

The simple and obvious answer is that the person who had the conversation should be the one who documents the file. However, this is not always practical. Producers spend a large percentage of time outside the office, and may not have ready access to the agency’s paper files or agency management system. Files need to be updated immediately, so that anyone speaking with the customer is working with the latest information. If there is going to be a delay before a producer can document a file, the information must be immediately transmitted to the CSR via telephone, fax, or e-mail to retain the integrity of the agency’s file. The best

course of action would be for the producer not to have the conversation in the first place, and to simply advise the insured to call the CSR directly. This does not always happen, however, so a process must exist whereby the producer transfers the information obtained in the conversation at the earliest possible time.

What Management Can Do

- ✓ Establish standards for file documentation
- ✓ Train all employees on proper file documentation
- ✓ Determine what method will be used for file documentation—electronic or paper, but not both
- ✓ Frequently monitor documentation by randomly pulling or looking at customer files to see if the record “tells the story” of the transaction
- ✓ Provide additional training when documentation is lacking
- ✓ Be willing to dismiss employees who habitually violate the agency’s file documentation procedures

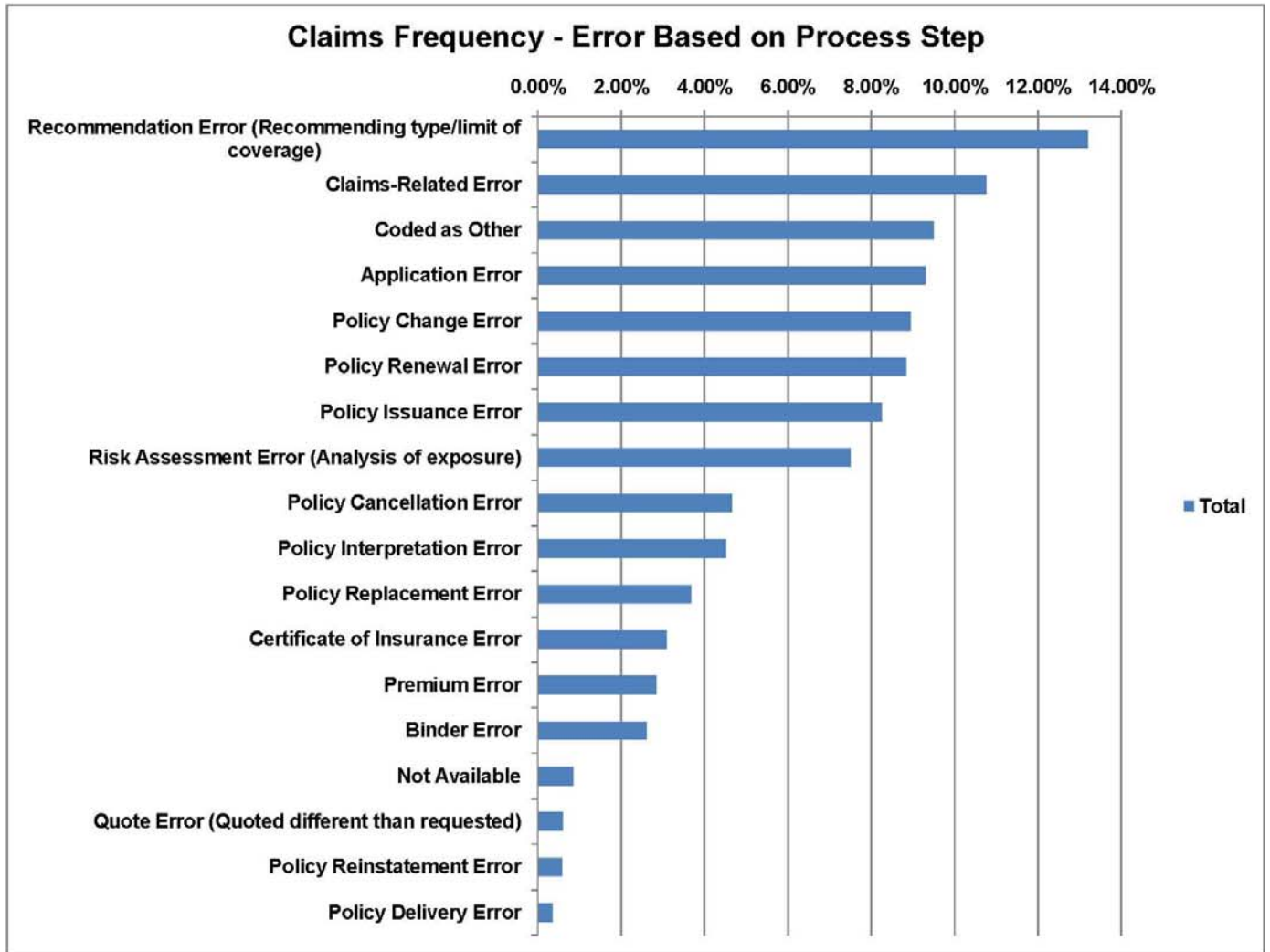
RISK ANALYSIS AND EXPOSURE IDENTIFICATION

The risk management process consists of several steps, including:

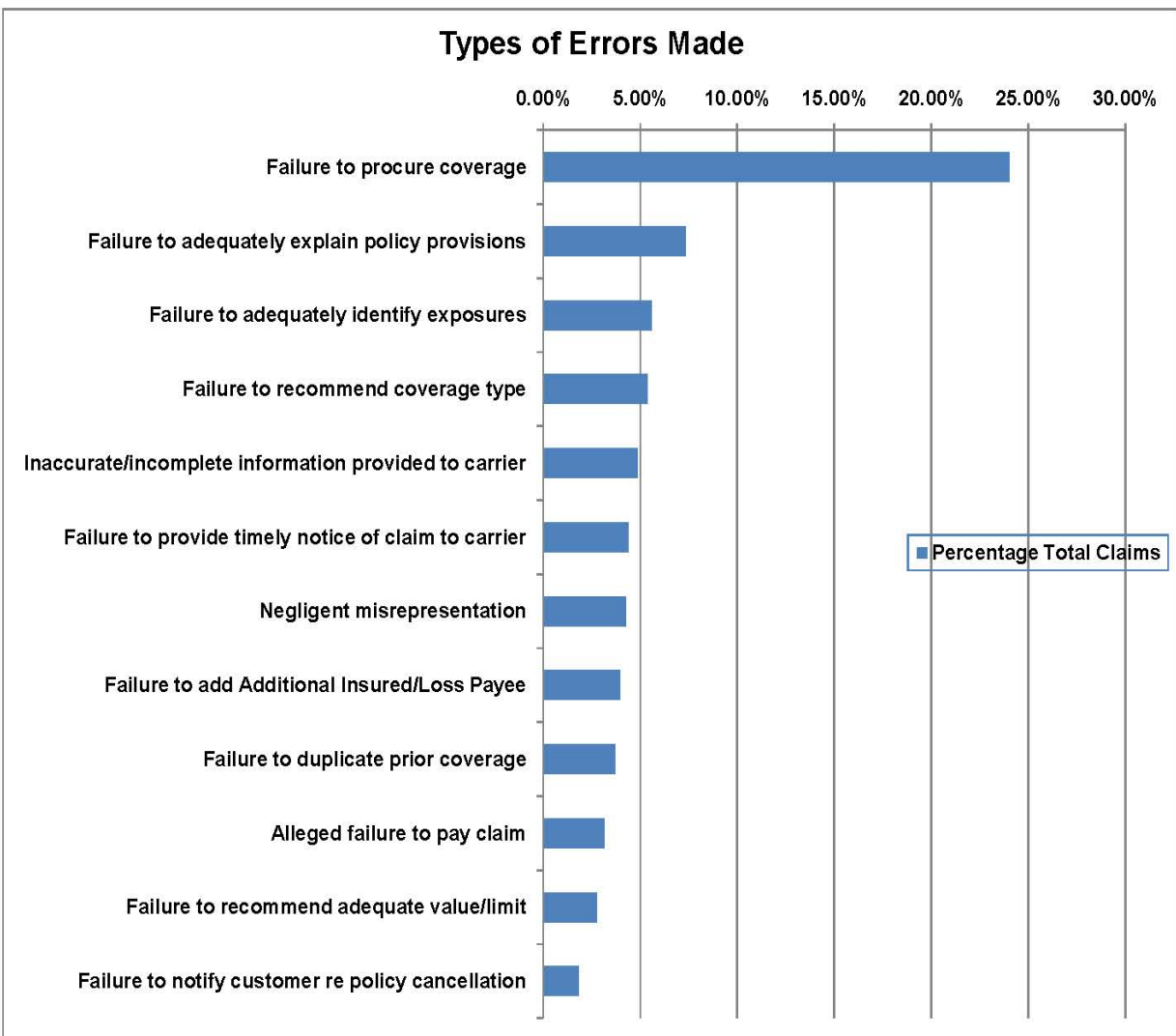
- ✓ Exposure identification
- ✓ Analysis of frequency and severity of potential losses
- ✓ Deciding which risk management technique to choose from
 - Avoidance (eliminating the exposure)
 - Loss control (reduction or prevention of loss)
 - Insurance
 - Non-insurance transfer (to another firm or organization via contract)
 - Retention, either active (by design) or passive (by doing nothing else)
- ✓ Implementing the chosen risk management method(s)
- ✓ Monitoring the decisions

Exposure identification is the first and, arguably, most important step in the risk management process. Recommendation errors are the leading processing step error of all claims. In addition, failure to procure coverage and failing to adequately identify exposures are the first and third most frequently seen errors.

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A Practical Guide to Agency E&O Risk Management



Without a thorough review of a person's or organization's loss exposures, the tools of risk management become limited. An exposure that is never identified will result in only one possible risk management treatment—passive retention. Since in some states agents or brokers may be considered risk managers for his or her customers, assistance with risk identification is one of the most important tasks that can be performed for a customer—a true added value. It is important to understand your state's standard of care and how involved the risk management process should be for meeting your customers' needs.

In a soft market that has been the norm for insurance professionals over the past decade or more, the focus has been primarily on price. When insurance is abundant and prices remain depressed, it is logical for the insured to make purchasing decisions that would appear irrational when the insurance market cycle changes. As the market begins to firm, buyers are faced with price increases and their insurance representatives will be increasingly called upon to help make the wisest use of the consumer's insurance budget, which may be fixed or even shrink as events in the economy change. Shopping for insurance will occur with more regularity as people and firms attempt to limit price swings. The producer who is able to bring the most value, in terms of protection, price, and service will be successful. Adopting a risk management perspective and fully utilizing all the tools in the risk manager's toolbox will be one way to differentiate oneself from among the other purveyors of insurance products and services.

Performing a thorough and comprehensive risk management audit for new and existing customers is essential to the implementation of an effective risk management program, as well as limiting errors and omissions exposures for the agency. While this process can be time-consuming, it is vital and must be a part of the professional services offered by every agency.

Identifying Exposures to Loss

There are several methods that can be used to evaluate loss exposures:

- Physical inspections
- Interviews
- Questionnaires and surveys/checklists
- Financial statement analysis
- Flowchart analysis
- Loss analysis

Each method has its pluses and minuses and the best approach is to use a combination of methods. Use of only one, typical with some producers, could result in a failure to recognize important loss exposures that may lead to the inadvertent use of retention as a risk management choice—and almost certainly to an E&O loss for the agency.

Physical inspections

One of the most useful, and underutilized, loss assessment methods is the physical inspection. It is true that this method is not always practical, such as when the insured has operations and locations that are widely dispersed geographically. When it is possible, however, inspections serve as an invaluable tool for both the agent and the underwriter. Many carriers have loss control representatives on staff that are invaluable in assisting agents with the physical inspection process.

Interviews

Interviews may be conducted in conjunction with physical inspections. Although it seems obvious that the owner of a business would be interviewed prior to placing insurance coverage, it may be wise to broaden this approach and interview others who are key to the operation. Often there is a manager or other supervisor who is more acquainted with the daily operations of the business and who may also speak to the owner's tolerance for risk. Meeting with an organization's employees may reveal other areas of risk that are not addressed in a typical insurance survey or inspection, but are nonetheless important from a risk management standpoint.

Questionnaires and Surveys

One of the most commonly used methods to identify exposures is the questionnaire, survey, or checklist. There are actually two different types of checklists, and the astute professional will be able to develop one that meets the needs of his or her customers.

Insurance Checklist

Although this type of checklist is readily available, either from producer trade organizations, educational providers, or insurance companies, it's obvious limitation is that it focuses on insurance when there may be other risk management techniques that are more appropriate. Use caution with these forms, as they may not provide as broad a range of questions as is necessary to do a true risk management analysis for the customer or prospect. The real advantage to the use of insurance surveys is that they tend to provide all the relevant information for the insurer's underwriting purposes.

Risk Management Survey

Unlike an insurance checklist, a true risk management questionnaire solicits information that is helpful in determining the presence of both insurable and uninsurable loss exposures. These checklists have their own limitations, however. Since they deal with a broad range of topics, they can be time-consuming and tedious to complete, and may not be practical on an annual basis. It is important to tailor any risk management survey to be industry-specific, since the needs of prospects and customers vary by industry. The questions that are appropriate for a restaurant will be completely different from those of a residential contractor.

Financial Statement Analysis

A review of a company's financial statements should be part of any loss exposure analysis. At minimum, the income (profit and loss) statement and balance sheet should be reviewed to discover or verify the presence of loss exposures. The income statement shows the sources of revenue for the individual or firm. The expenses can be a source of information for determining adequate amounts of indirect loss coverage. The balance sheet reveals assets and liabilities of the firm. Use caution with these statements. They are generally drawn up with an accounting spin, and thus may be of limited value in determining actual loss exposures. Property values, for example, can be shown at "book value" which includes depreciation. The appropriate risk management value, however, is cost to repair or replace, and so must be modified before use to determine insurance valuation or total loss exposure. An agent or broker should never determine the amount of insurance—this decision must always rest with the insured.

Don't forget the individual financial statements of the owners. In closely held corporations and sole proprietorships, many of the assets that need protection are found on these statements, not those of the business firm.

Flowchart Analysis

One of the most visual, and best, of the exposure identification methods is the flowchart. A flowchart is a drawing or diagram of the organization's operations. It shows inputs and how they are acquired, the process of transforming those inputs, and the output and distribution of products and services. Flowcharts are particularly useful in identifying an organization's business income exposures. They also identify "bottlenecks" in a production process, the dependence on certain suppliers, distributors, and methods of production, and various transportation exposures. It really is true that a picture is worth a thousand words. Some types of operations, such as agricultural or manufacturing, necessitate diagrams and flowcharts for underwriting purposes.

Loss Analysis

Obviously, an insurance professional will want to examine the loss experience of any prospect or customer. While this information is important from the insurance company's standpoint, it is also a source of information regarding an organization's insurable and uninsurable loss exposures. Loss analyses can be used to set retention levels that will eliminate small and predictable losses, and also determine maximum deductible or retention amounts that are in keeping with the organization's overall risk management philosophy. The limitation of a loss analysis is that it is historical and may not reveal new activities of the insured or those that have been discontinued or revised.

Which Method is Best?

The techniques listed above are by no means the only ways in which loss exposures can be identified. A risk management professional will use a variety of methods depending on the

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nature and complexity of the account and the relationship he or she has with the prospect or customer. In addition, the method to be employed may change over time, as a customer's operations change and grow. It is important that a number of different techniques be used to give an accurate picture of the insured's operations and an estimate of the total loss potential presented by each exposure. It is equally important to update all risk management information at least annually when conducting the pre-renewal meeting with the insured.

Disaster Planning

One of the most important things any individual, family, or organization can do from a risk management standpoint is to have a disaster plan. Much of risk management depends on an "if, then" scenario that is focused on the primary objectives of the person or firm. When an organization or individual must continue operations regardless of the circumstance, different decisions will be made as to how to deal with the associated risks of loss. If it is possible to curtail or even eliminate operations, different tactics would be used. What is most important is to have a plan, prepared well in advance of any event, which addresses all the possibilities for dealing with the risks of loss.

In determining how to handle loss events, two measures are important: maximum possible loss and probable maximum loss.

Maximum Possible Loss

This scenario deals with the worst possible loss at the worst possible time. In other words, it's yours or your customer's worst nightmare. The reason it is important is that it determines the outer limit—for insurance purposes or for risk management. Although it is unlikely that it will happen, it could, and therefore is deserving of careful consideration.

Probable Maximum Loss

The largest loss that is *likely* to occur may be far less than the maximum *possible* loss. Loss control devices, when performing as they should, will limit the number of losses that occur or the financial impact of losses. Although risk managers must consider total "wipe-out", they must also deal with a "best case scenario" that may influence the risk management techniques they use.

Underwriters will be concerned with both maximum possible loss (which they refer to as "amount subject") and probable maximum loss (PML). This approach, however, is not broad enough for an insured who must deal with the total loss concept. Again, this means the worst possible loss at the worst possible time and includes property, liability, workers' compensation, marine, professional liability, and any other exposures that the firm faces and that may be involved in a single loss situation.

Assisting a prospect or insured in preparing a comprehensive disaster recovery plan can be an important value-added service. The agency need not be an expert at preparing such a plan, since there are firms that specialize in this field. What is important, however, is that the producer be involved in the planning process, since insurance will be the primary method of recovery for most customers.

What the Producer Can Do

- ✓ USE A CHECKLIST!
- ✓ If you are not skilled at the risk management process, become educated so you can better assist your customers with these important decisions
- ✓ Find out about your firm's expertise and resources when it comes to risk management
- ✓ Don't hold yourself out to be something you aren't—stay within your areas of expertise

What the CSR Can Do

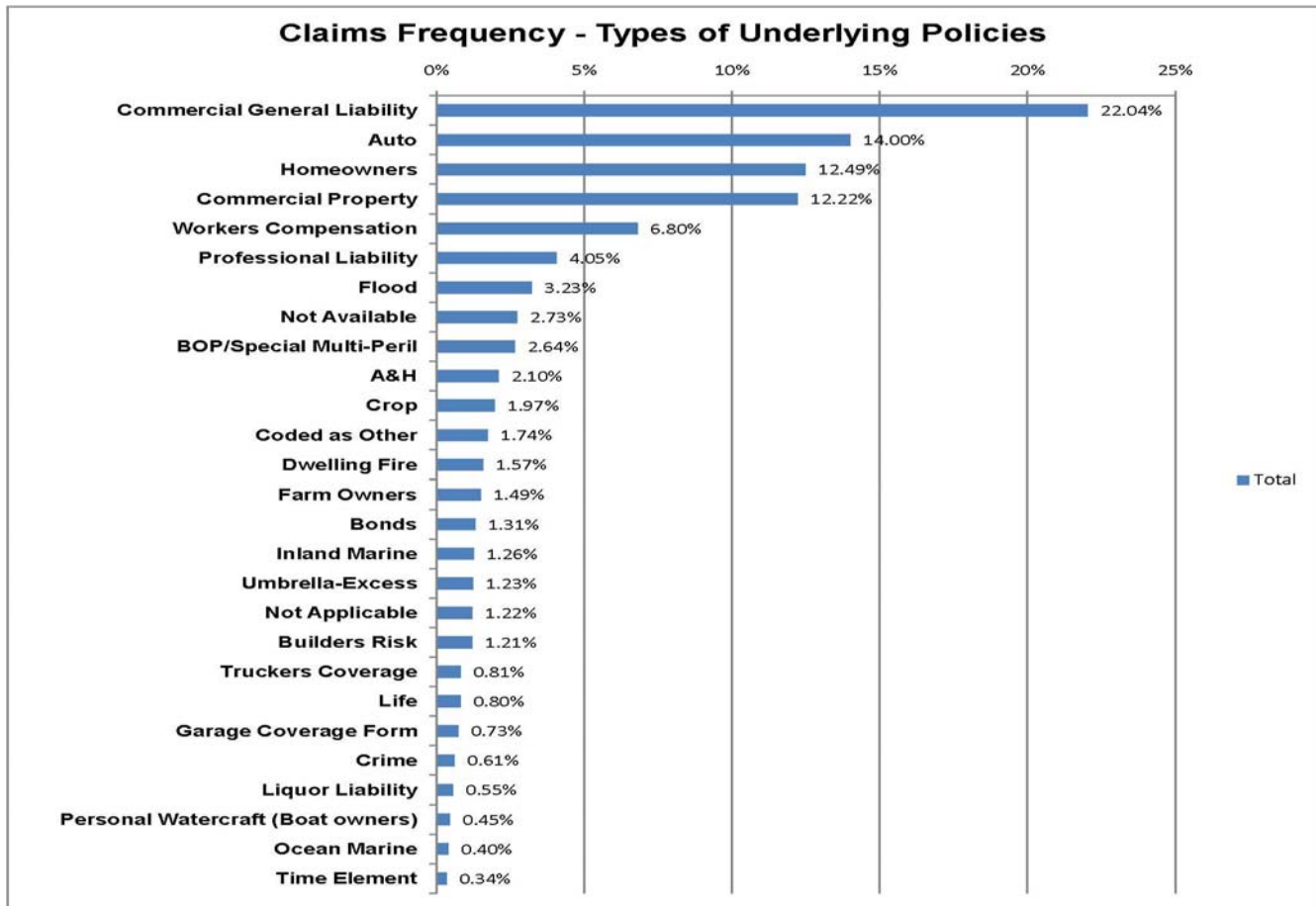
- ✓ Assist the producer in the completion of checklists and surveys
- ✓ Prepare a narrative of the insured's operations, with the help of the producer
- ✓ Inform the producer if you discover exposures that have not been addressed
- ✓ Provide the customer with documentation as to how their loss exposures have been handled (what will be insured and what will not)

What Management Can Do

- ✓ Provide tools and resources to producers and CSRs to aid them in completing a thorough risk analysis for each prospect or customer
- ✓ Require continuing education of all agency employees on risk management topics
- ✓ Require testing of new hires to determine their level of risk management and insurance knowledge

COVERAGE TRAPS AND TRICKS

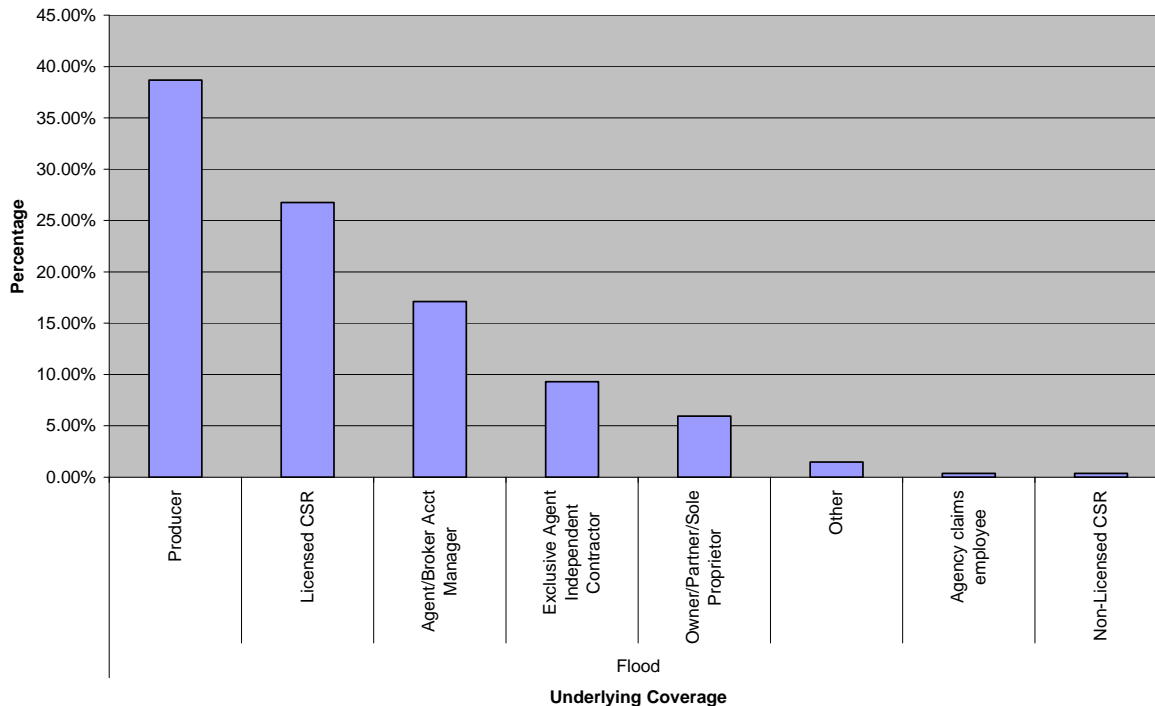
Errors and omissions carrier loss data suggests that failure to procure coverage drives a large percentage of agency E&O claims. While agents cannot be held responsible to recommend every conceivable type of coverage to every customer, there are a number of areas which, if not addressed, may lead to an E&O claim.



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Flood Insurance

National Agent E&O Claims Frequency - Person Involved in Flood Claims(Jan. '04 to Dec. '06)



If the hurricane seasons of the last several years have taught us nothing else, it is the importance of offering flood insurance to customers and getting a signed rejection when coverage is not taken.

Although it is commonly accepted among insurance professionals that flood is an excluded cause of loss in most property insurance policies, this fact is not as apparent to insurance consumers. Lenders typically require flood insurance for property located in one of the federal “special flood hazard areas” through the government’s National Flood Insurance Program (NFIP). However, there is a risk of flood damage, albeit much smaller, in areas outside the NFIP flood zones, and we cannot rely on lending institutions to identify exposures to flood losses. Also, when coverage is being pursued by the lender, its only interest is in protecting the buildings and contents coverage can be overlooked.

Floods can occur in any region of the United States, not just in the Gulf Coast areas of Florida, Louisiana, Alabama, Mississippi, and Texas and not simply in ocean front areas. Therefore, it

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is important to alert policyholders to the exclusion for flood damage and to offer coverage to all customers, not just those who qualify for the NFIP.

Even if coverage is provided by the federal program, limits are often less than the full value of the property. It is important to offer excess flood coverage, whenever possible, to bring the limit of insurance up to the full insurable value of the property.

Big “I” Advantage Products and Services – Insurance Markets

Big “I” National Flood Program:

Offering flood insurance to every customer may reduce your agency’s E&O exposure. Big “I” members have access to the Big “I” National Flood Program and the underwriting carrier, Selective Insurance Company. Flooding can occur at any time of year, and can result from many different types of meteorological events—not just rain. And it is not only important for independent agents to recognize the need for flood insurance, it is important that consumers understand the importance of flood insurance as well. Visit www.independentagent.com/flood to learn more about accessing this valuable coverage.

Types of E&O Losses

- ✓ Failure to offer flood coverage
- ✓ Failure to advise of limitations and exclusions in property policies
- ✓ Failure to provide adequate limits of insurance for flood losses
- ✓ Inadequate limits for Business Income or Additional Living Expense coverages
- ✓ Not offering/recommending Contents coverage in addition to Building coverage

What the Producer Can Do

- ✓ When meeting with prospects or customers, remind them that flood is not a covered cause of loss in most policies—document all such conversations

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- ✓ Recommend in writing and quote, if possible, flood coverage in all proposals
- ✓ Advise prospects and customers immediately in writing whenever flood coverage is unavailable
- ✓ When delivering new or renewal policies, point out the exclusion for flood and restate your previous recommendation—document all such conversations
- ✓ Use coverage checklists to ensure that you exercise “reasonable diligence” when addressing a prospect or customer’s loss exposures—and have the insured initial or sign each checklist
- ✓ Confirm in writing any coverage recommendations rejected by the insured

What the CSR Can Do

- ✓ Provide all customers with a Flood Insurance Acknowledgment Form and obtain their signature every year
- ✓ Obtain quotes for excess flood insurance whenever property values exceed the maximum limits under NFIP
- ✓ Send a confirming letter to any customer who rejects flood coverage, and advise them of the process for securing flood coverage in the future, including waiting periods
- ✓ Check all flood and excess flood policies for accuracy
- ✓ When making changes to a property policy (e.g., Homeowners, Commercial Property, etc.) be sure to make a corresponding change to the flood policy
- ✓ If coverage has been placed in a non-standard market using an Excess or Surplus Lines Broker, carefully review all policy provisions as terms and conditions vary
- ✓ When renewing coverage for an insured who has previously rejected flood coverage, advise them they do not have the coverage and what must be done to secure it

What Management Can Do

- ✓ Require staff attendance at meetings offered by FEMA or other providers to acquaint them with the operation of the National Flood Insurance Program

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- ✓ Obtain stickers from NFIP (or a stamp) that read: “NOTICE! THIS POLICY DOES NOT COVER FLOOD LOSS” and require their use on all property proposals and policies
- ✓ Run a report of all customers who do not currently have flood coverage and send each customer a letter advising they obtain coverage
- ✓ Run a report of all customers who have purchased flood coverage on buildings, but not on contents, business income, or other exposures and send each a letter recommending coverage
- ✓ Send flood recommendation letters on an annual basis to all customers—in advance of flood season
- ✓ Advise customers how to contact the agency in the event of a disaster
- ✓ Establish a written procedure for handling flood insurance

NOTE: Most of the above loss control tips apply equally to a recommendation of Earthquake insurance

Claims Made Commercial General Liability

Professional Liability policies have been provided on a Claims Made basis for many, many years and seem to create few E&O problems for agents. While certainly not common, in some cases, such as high-hazard or so called “long-tail” general liability exposures, a carrier might only be willing to provide the Commercial General Liability policy on a claims made basis.

Care must always be exercised when placing general liability coverage on a claims made form. Often the policy is issued using non-ISO forms and endorsements and proprietary language. Substantial restrictions and limitations may be contained in such a policy. Some states require that any claims made policy be stamped with a special notice on the declarations page alerting the insured to the fact they have purchased a claims made policy.

The terms and conditions for purchasing the Extended Reporting Period (“tail”) option under the policy can also vary from carrier to carrier. The ERP is necessary when:

- ✓ Coverage is changed from claims made to occurrence
- ✓ Replacement claims made coverage does not include “prior acts”
- ✓ Replacement claims made coverage requires advancing the insured’s retroactive date

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Since a claims made policy requires a “dual trigger” for payment of claims, the happening of the occurrence after the retroactive date AND the claim being first made against the insured during the policy period, any change to a policy with different terms will necessitate the offer of the ERP.

Some claims made policies give the insured 30 or 60 days following expiration to purchase the tail. Most specify that the request must be in writing and received by the insurer within that time frame. The policy provisions often include the cost to purchase a tail, based on the amount of extended reporting time selected. Other policies may require the insured to elect the tail *prior to* expiration of the policy. Once the time period has passed, it is not possible to secure tail coverage.

Once purchased, the premium for an ERP is fully earned and the coverage cannot be cancelled. Purchase of an ERP generally coincides with the insured’s renewal, and thus creates a financial burden if the insured was not prepared to make the purchase.

In a standard ISO claims made CGL policy, the limits originally purchased under the policy are reinstated during the ERP. Non-standard forms may or may not be as generous.

Types of E&O Losses

- ✓ Failure to advise of the need to purchase an ERP
- ✓ Not disclosing “gaps” created when moving from claims made to occurrence policies
- ✓ Not advising an insured of the time period to elect an ERP
- ✓ Failure to advise the cost of an ERP

What the Producer Can Do

- ✓ Advise all prospects and customers of the differences between claims made and occurrence policies—document all such conversations
- ✓ Perform a “diligent search” of the marketplace to obtain occurrence coverage or, if necessary, claims made coverage on the most favorable terms
- ✓ When delivering policies, advise the insured in writing of any special restrictions or limitations contained in a claims made general liability policy

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What the CSR Can Do

- ✓ Examine every claims made policy to determine the specific provisions for the ERP
- ✓ Set a suspense to contact the insured well prior to any deadline to purchase an ERP
- ✓ When sending out policies, advise the insured in writing of any conditions required to purchase an ERP

What Management Can Do

- ✓ Provide specific training of staff on the appropriate use of claims made policies
- ✓ Run a report of all claims made policies to ensure proper handling
- ✓ Establish a written procedure for dealing with claims made policies

Business Income Coverage

While nearly every business customer has some exposure to Business Income or Extra Expense losses, not every person with the exposure purchases appropriate coverage. In some cases, this is a conscious risk management decision. In other cases, it is something the agency has not discussed adequately with the customer.

Serious E&O losses can happen when an insured receives payment for property damaged as a result of a loss, but is not compensated for lost income or reimbursed for extraordinary expenditures following direct damage to their buildings, contents, or equipment. It sometimes happens that a relatively minor direct loss can result in a very large indirect loss in the form of lost revenue.

On larger Commercial Property policies, Business Income and Extra Expense coverage is optional. In addition, coverage can be provided in a number of ways:

- ✓ Business Income (and Extra Expense)
- ✓ Business Income (without Extra Expense)
- ✓ Maximum Period of Indemnity
- ✓ Monthly Limit of Indemnity
- ✓ Agreed Value
- ✓ Extended Period of Indemnity

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Obtaining the proper form of coverage is essential to avoiding disputes following a loss. Each of the forms is created to fit a particular need and producers should acquaint themselves with the differences between these products, as well as the proper use of each form.

After selecting the proper type of coverage, the next step is to determine the limit of insurance. Even if the appropriate type of insurance has been arranged, an E&O loss is likely if the insured is only partially protected. Typically, an insured will not understand the somewhat complex method used to compute the required amount of insurance. A “plain English” explanation will go a long way toward helping the insured make a sound decision regarding the amount of insurance to purchase.

Many options are available when arranging Business Income coverage on a Commercial Property policy. Each should be carefully considered in light of the prospect’s or insured’s situation, and appropriate recommendations made to the applicant. Some of the coverage options include:

- ✓ Ordinary Payroll Limitation or Exclusion
- ✓ Premium Adjustment Endorsement
- ✓ Dependent Properties Endorsements
- ✓ Ordinance or Law—Increased Period of Restoration
- ✓ Utility Services—Time Element
- ✓ Educational Institutions Endorsement
- ✓ Power, Heat and Refrigeration Deduction Endorsement
- ✓ Blanket Insurance

The use of Business Owner Policies (BOP) in recent years seems to have lessened the need to carefully consider Business Income coverage needs. This can have the unintended effect of increasing an agency’s E&O loss exposures.

Under most carrier BOP policies, Business Income coverage is included on an Actual Loss Sustained basis. Some people consider this to be “unlimited” coverage because no dollar limit is included in the policy. Quite the contrary—coverage is limited to the extent that it is only provided for 12 months following a loss, and usually cannot be endorsed to provide a longer period of time. In serious loss situations, such as the events of September 11, 2001 or the hurricanes of 2004 and 2005, loss of revenue and extra expenses extended well beyond one year following the direct damage. When coverage has been improperly arranged, and the impact not disclosed to an insured, the agency can be held responsible.

Types of E&O Losses

- ✓ Failure to obtain indirect loss coverage
- ✓ Not adding coverage for new locations

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- ✓ Failure to arrange proper coverage
- ✓ Failure to advise of restrictions and limitations in policies
- ✓ Providing inadequate amounts of coverage

What the Producer Can Do

- ✓ Discuss the importance of indirect loss coverage with every prospect and customer—and document all such conversations
- ✓ Use a “worst case scenario” approach with the applicant to determine the maximum possible loss and probable maximum loss
- ✓ Never use the Business Income (without Extra Expense) coverage form
- ✓ Document in writing any coverages or coverage options recommended and rejected by the insured

What the CSR Can Do

- ✓ When completing applications, alert the producer if indirect loss coverage has not been selected
- ✓ Whenever possible, use endorsements that waive or suspend any coinsurance clause in the policy
- ✓ When making changes to other sections of the policy, be sure to consider if the change applies to the Business Income coverage as well
- ✓ Advise the insured in writing of any special restrictions or limitations in their Business Income coverage
- ✓ Require a signed rejection when coverage has been offered to but not taken by the insured
- ✓ When renewing policies, be aware that increases in sales or revenue for the insured may require an adjustment of their Business Income limit

What Management Can Do

- ✓ Provide specific training to staff regarding indirect loss exposures and their treatment

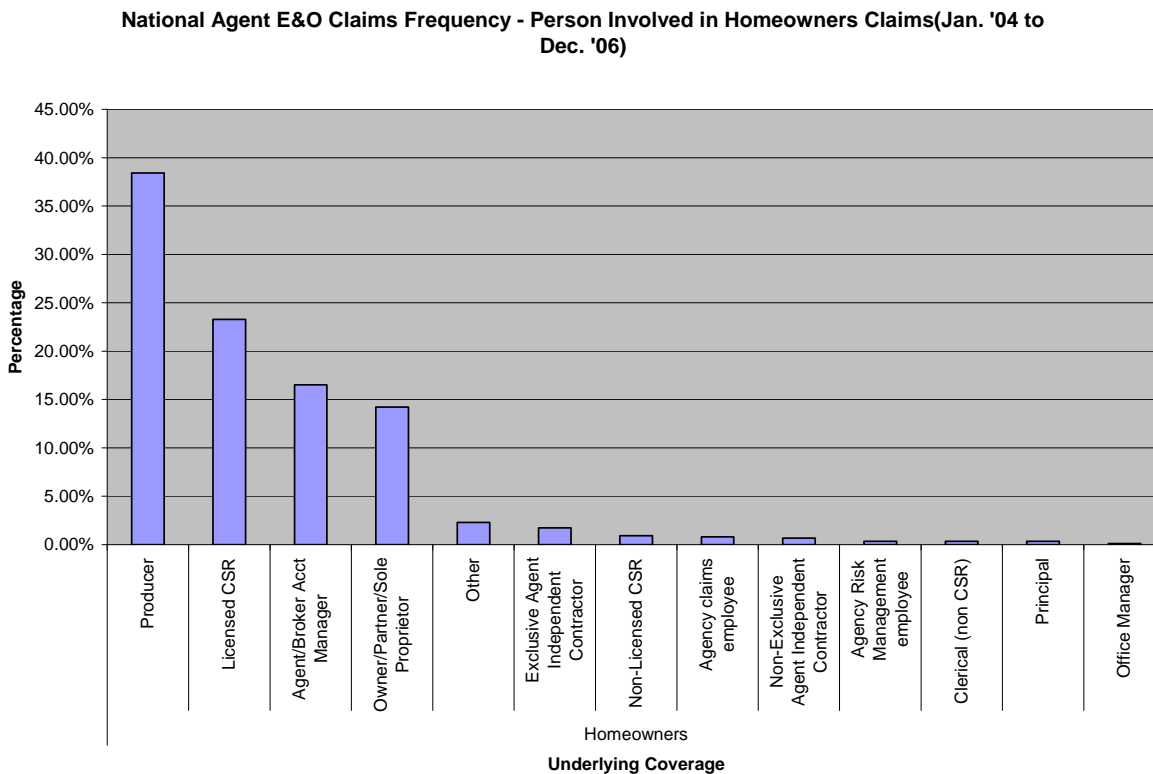
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- ✓ Run a report to identify any customer without Business Income coverage and prepare a letter to be sent to each customer recommending the coverage
- ✓ Establish a written procedure regarding Business Income coverage

Other Coverages

No one can be expected to remember every possible endorsement or policy provision. That is why checklists are an invaluable tool for every agent. The following are some of the problem areas that could result in an E&O loss if not addressed with a customer:

Homeowners



- ✓ Pre-set limits for Other Structures (10%), Personal Property (50-75%) and Additional Living Expense (20-40%) should be reviewed for adequacy
- ✓ Ordinance or Law coverage should always be recommended
- ✓ Earthquake and Flood coverage should be quoted

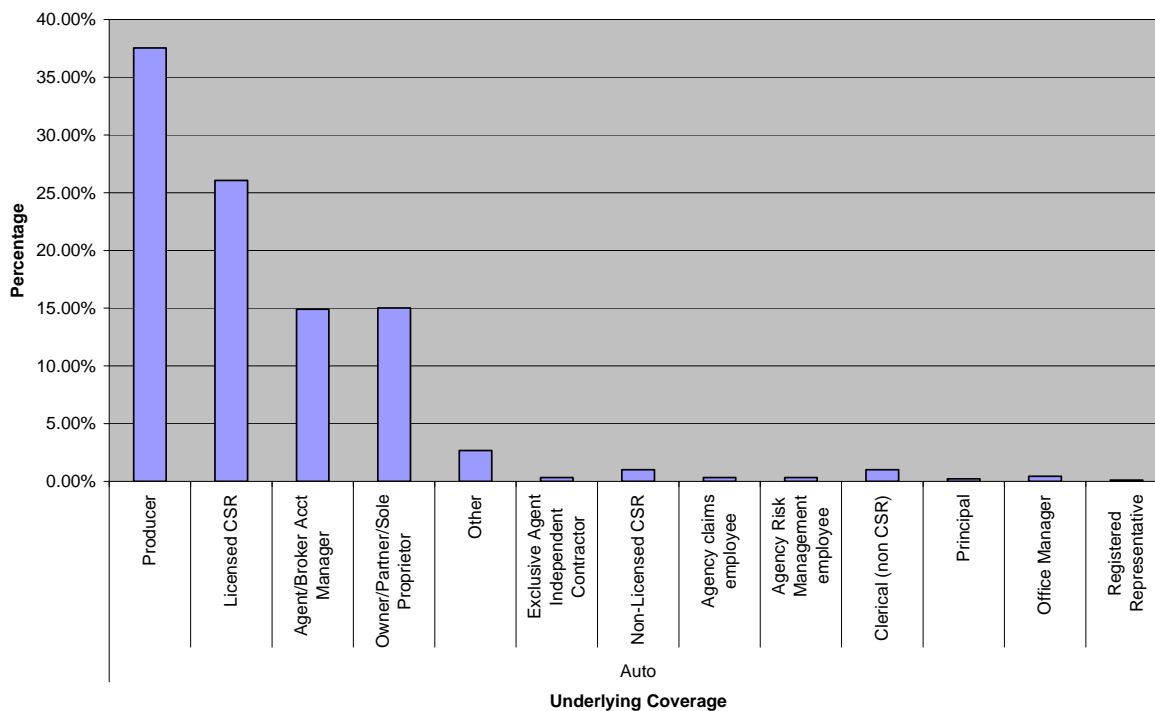
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- ✓ “Special Limits” for jewelry, silverware, watercraft, etc. should be reviewed with the insured
- ✓ Replacement cost coverage for Personal Property should always be included
- ✓ Quote an upgrade to a Comprehensive Form (HO-5 or similar) that will include open perils coverage on Personal Property
- ✓ Advise all customers that coverage for home-based businesses is extremely limited (property) or non-existent (liability)
- ✓ Provide high limits for Personal Liability coverage, and quote a Personal Umbrella

Personal Auto

National Agent E&O Claims Frequency - Person Involved in Auto Claims (Jan. '04 to Dec. '06)



- ✓ Beware of driver exclusions or limits that drop down when a non-named driver is using the vehicle
- ✓ Advise the customer to report new vehicles immediately—there is only limited coverage for newly acquired vehicles
- ✓ Match Uninsured/Underinsured Motorist limits to the insured’s liability limit wherever possible
- ✓ Don’t encourage the insured to reject UM/UIM, even in a state where it is permissible

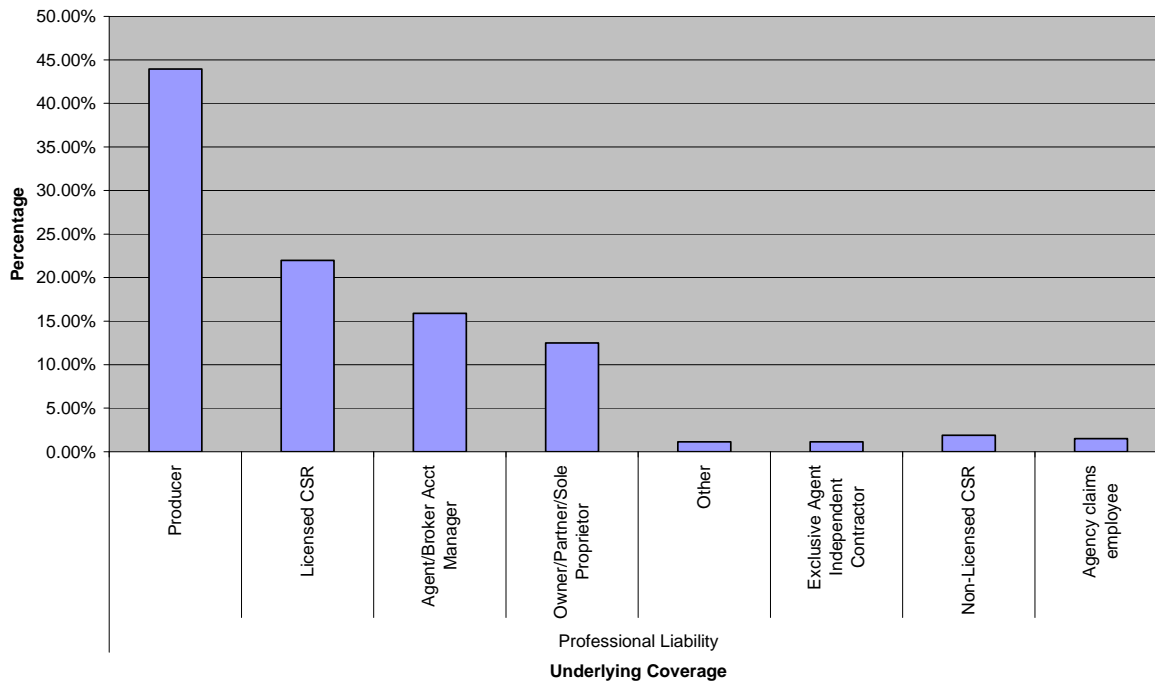
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A Practical Guide to Agency E&O Risk Management

- ✓ Provide high limits for Bodily Injury and Property Damage, and quote a Personal Umbrella
- ✓ Remember that an umbrella usually does not apply to UM/UIM claims

Professional Liability

National Agent E&O Claims Frequency - Person Involved in Professional Liability Claims (Jan. '04 to Dec. '06)

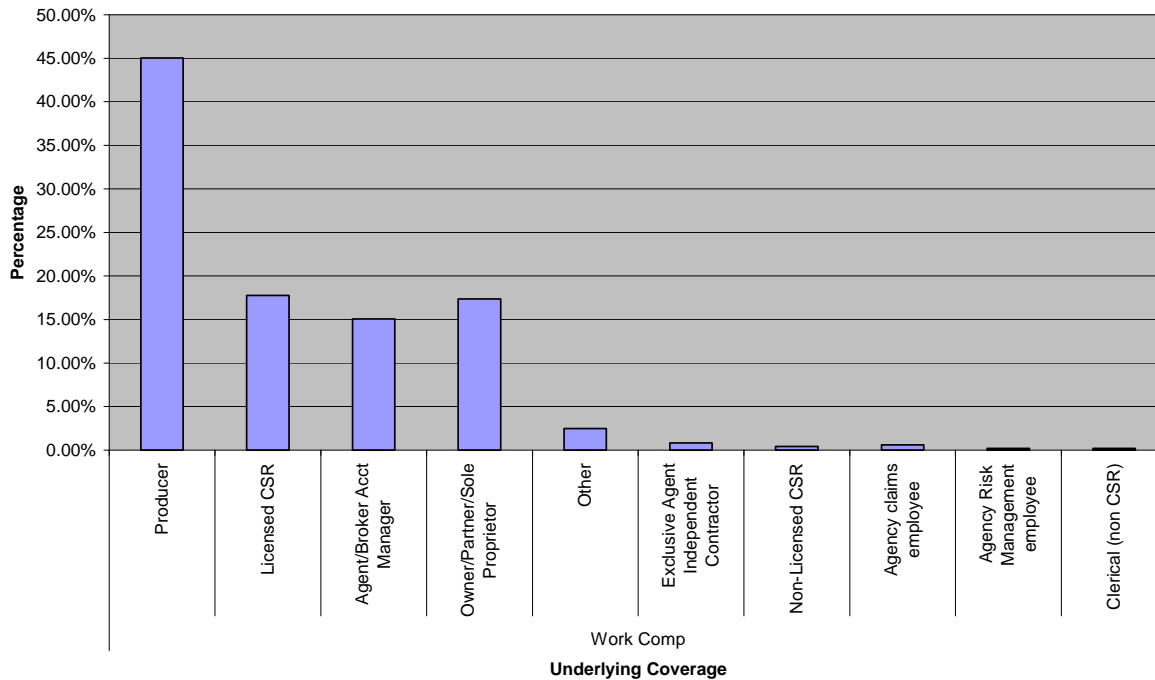


- ✓ Claims made policies should never have an advanced retroactive date
- ✓ Remember to offer “tail” coverage if a retroactive date must be advanced, or if the insured retires or goes out of business
- ✓ Note the definition of “professional services” and advise the insured of any limitations
- ✓ Remind the insured of the consequences of placement with a non-admitted carrier

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Workers Compensation

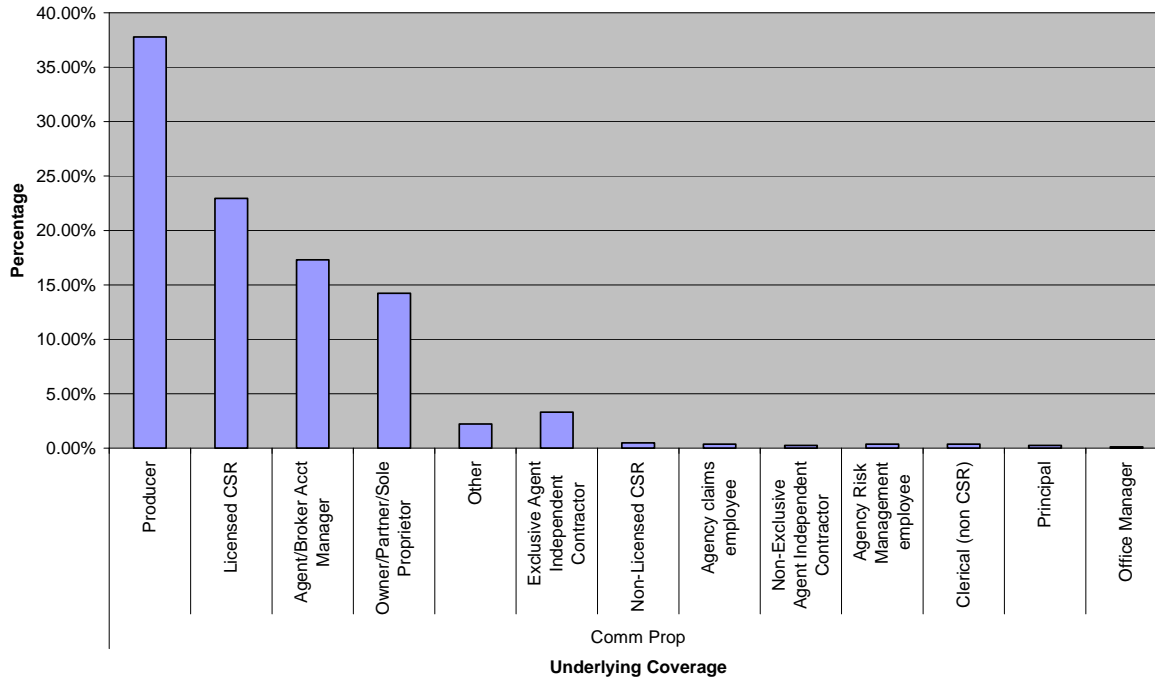
National Agent E&O Claims Frequency - Person Involved in Workers Comp Claims (Jan. '04 to Dec. '06)



- ✓ Become familiar with the laws and regulations in your state pertaining to workers compensation
- ✓ Advise your customers that independent contractors are often held to be employees following an injury
- ✓ Advise customers of the importance of immediate reporting of operations commencing in other states
- ✓ Include appropriate endorsements, even when no exposure is apparent:
 - USLHWCA
 - Voluntary Compensation
 - Maritime Employment
 - All States

Commercial Property

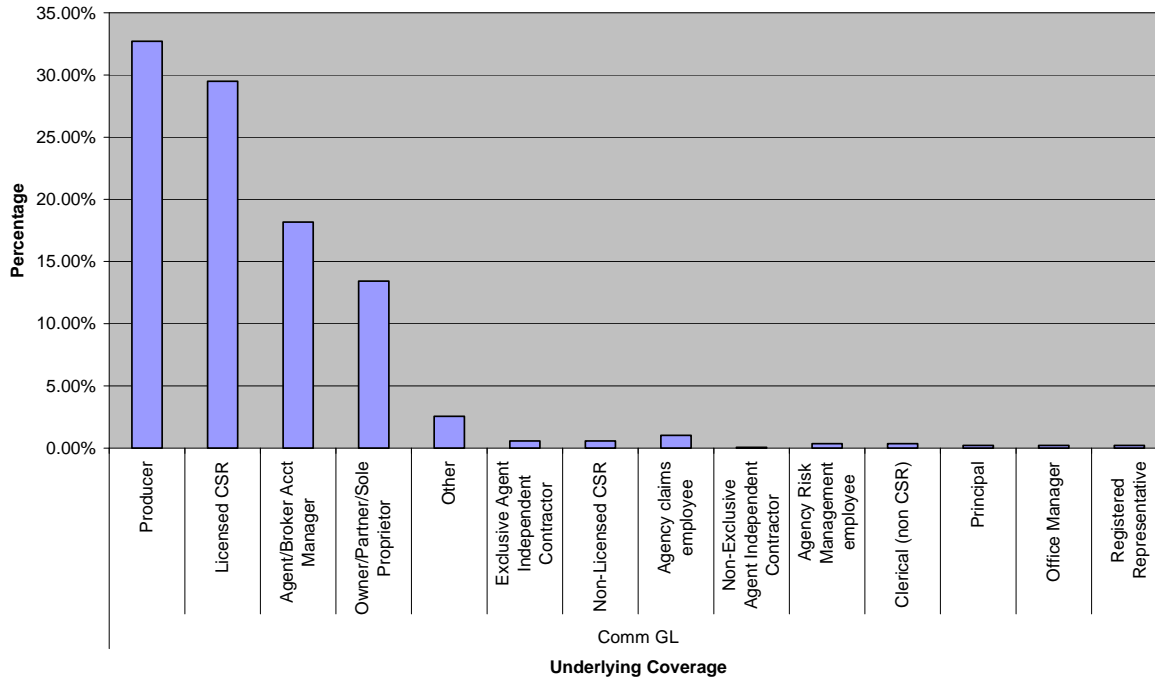
National Agent E&O Claims Frequency - Person Involved in Commercial Property Claims (Jan. '04 to Dec. '06)



- ✓ Include indirect loss coverage in all quotes and proposals
- ✓ Ask about exposures for Tenants Improvements and Betterments and Leasehold Interest
- ✓ Recommend the purchase of Ordinance or Law coverages
- ✓ Recommend Earthquake and Flood or a Difference in Conditions policy
- ✓ Provide Special Causes of Loss whenever possible
- ✓ Be careful of the valuation basis for covered property—actual cash value, replacement cost, selling price, etc.

Commercial Liability

National Agent E&O Claims Frequency - Person Involved in Commercial General Liability
(Jan. '04 to Dec. '06)



- ✓ Point out exclusions for Employment Practices Liability and provide a quote to all policyholders
- ✓ Carefully examine any non-standard policies for differences in definitions, conditions, and exclusions
- ✓ Provide high limits of liability, and quote a Commercial Umbrella or Excess Liability policy
- ✓ Ask the insured about any professional liability exposures
- ✓ Remember to add Non-owned and Hired auto coverage if there is no Business Auto policy in place
- ✓ Add Employee Benefit Liability to policies for every customer with employees
- ✓ Discuss the terms and conditions of requested certificates of insurance

EXCESS AND SURPLUS LINES AND OTHER NON-STANDARD MARKETS

Overview

At times it is necessary to approach alternative markets for the placement of a customer's insurance, rather than one of the agency's standard contract carriers. Excess and surplus lines business is highly regulated in most states, and requires heightened awareness and special procedures on the part of agency personnel.

The major issue that must be addressed with the use of Excess and Surplus Lines business is that coverage may be offered by a non-admitted or unapproved carrier. Coverage may be issued with a non-admitted carrier under certain circumstances, outlined in your state's surplus lines laws and regulations, but coverage should never be placed with an unapproved insurer. Most states also prescribe the method by which a policyholder is to be informed of coverage placed with a non-admitted insurance company and the fact that any state guaranty fund would not apply to unpaid losses should the company become insolvent. It is generally not permitted by state law to "export" business to a non-admitted carrier for reason of price alone.

Many states also require someone in the agency to hold a Surplus Lines license in order to transact insurance in the non-admitted market. Be sure to become familiar with the law in all states where your agency conducts business before placing such business.

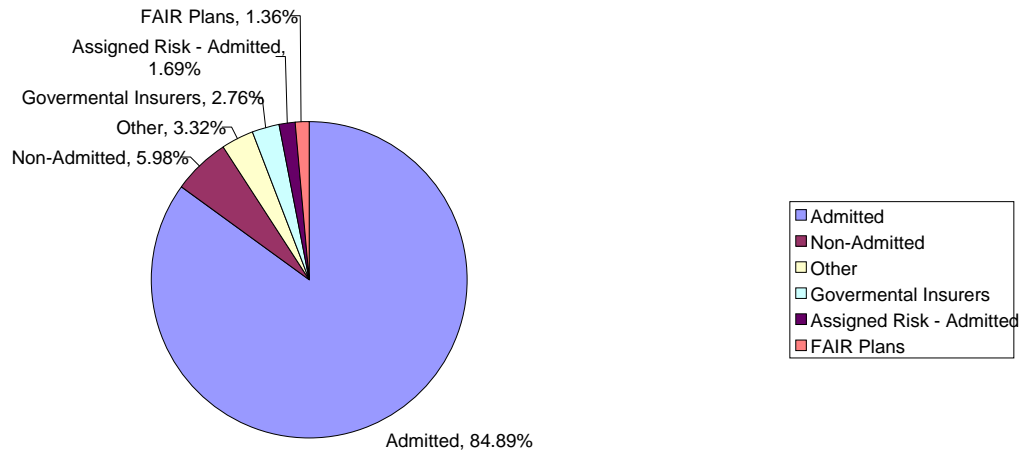
When deciding which Surplus Lines brokers to use, an agency should perform due diligence similar to that used deciding which carriers to represent. The Surplus Lines brokers should be asked to provide evidence of E&O insurance at least equal to the limit the agency carries to protect the agency in the event of a problem.

Many of these concepts apply equally to business placed through a Managing General Agent (MGA). Exercise caution before deciding to use an MGA, since business placed on your behalf by others may not meet your agency's practices.

The policy terms and conditions vary greatly in the non-standard market and it is important to thoroughly review the provisions of any policies proposed to an insured.

A Practical Guide to Agency E&O Risk Management

National Agent E&O Claims Frequency - Top Six Type of Insurers Involved in E&O Claims



Types of Typical E&O Claims

- ✓ Placing insurance with an unapproved or insolvent insurer
- ✓ Not disclosing to an insured that coverage has been placed with a non-admitted carrier
- ✓ Not obtaining coverage in a standard market when one is available
- ✓ Misrepresenting the agency's authority to bind coverage or issue certificates of insurance or other documents

What the Producer Can Do

- ✓ Be familiar with the laws and regulations in states where accounts you work on are placed as Excess and Surplus Lines business
- ✓ When preparing proposals or making presentations, point out to the insured whenever coverage is proposed to be placed in a non-standard market

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- ✓ When delivering policies to the customer, alert the insured to the fact that coverage may be more restrictive or limited than with standard insurers and identify those limitations in writing and document in the file and consider providing specific exclusions that are restrictive
- ✓ Have the insured sign an acknowledgment when placing coverage in the non-standard market

What the CSR Can Do

- ✓ Be familiar with the laws and regulations in states where accounts you work on are placed as Excess and Surplus Lines business
- ✓ Include a written disclosure on all quotes, proposals, and policies that coverage is placed with a non-admitted carrier and what the consequences are of such a placement
- ✓ Separately disclose all taxes, fees, and other charges (apart from the actual premium) when preparing invoices for the insured
- ✓ Request binders and certificates of insurance from the insurance carrier, Surplus Lines broker, or MGA—or obtain written approval for the agency to issue these documents
- ✓ Advise the insured that changes to the policy cannot take effect until it is confirmed by the insurance company
- ✓ Notify the insured in writing of any unusual restrictions, limitations, terms or conditions and document the file accordingly
- ✓ When preparing documents and invoices, be sure to accurately reflect the insuring (or issuing) company versus the “billing company” (the E&S broker or MGA)—this will enable the agency to run reports should you need to identify policies issued with a certain carrier and will also provide accurate information that will “pull” to certificates and other documents
- ✓ Prepare and transmit any forms required by your state to demonstrate that a diligent search of the admitted market was conducted prior to placement with a non-admitted insurer

What Management Can Do

- ✓ Be judicious when deciding how many and which Surplus Lines brokers or MGAs with which to do business
- ✓ Use due diligence when deciding to do business with any Surplus Lines broker or Managing General Agent
- ✓ Obtain a copy of the E&O policy carried by the Excess and Surplus Lines Broker or MGA and review it to be sure it satisfies your requirements
- ✓ Obtain any necessary licenses that are required by states in which you conduct business to access the Surplus Lines market
- ✓ Keep informed on financial issues that pertain to Surplus Lines carriers, including when an insurer becomes unapproved in your state
- ✓ Establish a written procedure for dealing with Surplus Lines brokers, non-standard markets, and MGAs and be sure appropriate staff are trained on it

CERTIFICATES AND OTHER EVIDENCE OF INSURANCE

It's hard to imagine that a single sheet of paper, with no less than three disclaimers printed all over it, could cause an agency to suffer an E&O loss. In the past, many courts generally did not recognize a separate cause of action brought by a third party certificate holder against an insurance agency. Times and attitudes have changed, and one of the most alarming trends on the E&O front is the amount of litigation over certificates of insurance and additional insured endorsements.

Big "I" Member Benefit:

Certificates of Insurance: Issues and Answers

The Big "I" Virtual University has published a 53-page white paper entitled "Certificates of Insurance: Issues and Answers." The complete paper is available for FREE to IIABA member agencies and paid VU subscribers and looks at many of the issues regarding certificates of insurance that agents face every day. To access the paper, visit www.independentagent.com/VU.

Agencies are often asked to amend or alter a pre-printed certificate, or to include special wording in the description field of the certificate. The typical requests often involve:

- ✓ The number of days notice of cancellation
- ✓ Crossing out the "endeavor to" wording in the cancellation clause
- ✓ Including waiver of subrogation wording
- ✓ Primary and non-contributory wording
- ✓ Attachment of outdated or unavailable Additional Insured endorsements (CG 20 10 11/85)

Although a certificate, in and of itself, confers no rights upon the holder, agents have routinely been asked to alter the wording on the certificate, which may breach their agency appointment contract with the carrier and create a liability where none might otherwise have existed. An insurance company is never legally obligated to provide notice of cancellation to a third party certificate holder, even if that entity is named as an additional insured under the policy, unless the

policy itself has been so endorsed. However, when an agency crosses out the "endeavor to" or "but failure to mail" wording in a certificate, and then signs as the authorized representative of the insurance company, it may be argued that the agency is obligating the carrier to mail notice of cancellation. Most agencies probably have no procedure for notifying certificate holders of the termination of a policy or any intention to do so.

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Some agencies routinely include in the description box on a certificate the words “XXX is hereby added as an additional insured” when in fact the only way to accomplish adding the certificate holder as an insured is to endorse the policy. Proclamations like this when, often not backed by an endorsement, can be used against an agency when contractual risk transfer is not accomplished.

Alteration of certificates has become such a widespread problem in the industry that several states have made the certificate a “filed form”, meaning that it is illegal in those states to alter in any way the pre-printed wording on the form, without prior approval of the Department of Insurance or other regulatory body with jurisdiction. This should go a long way toward helping an agent fend off the numerous requests they receive to make modifications to the form, but these laws and regulations are far from universal. Agents should also keep in mind that the appointment contract they have with carriers, or guidelines issued by the carrier, also may bar the agent from altering any forms, including the certificate, without prior written permission of the company. If an agent nonetheless makes changes to the certificate, then if there is a claim against the agent, the carrier may argue that the agent’s action and/or breach of contract invalidates any indemnification otherwise available from the company.

A potentially larger problem with certificates is that they are often delegated to a person in the agency who has only limited insurance knowledge and experience. Certificate issuance is sometimes perceived as a “clerical” function, and therefore not that important. On the contrary, proper handling of certificates requires more than a rudimentary knowledge of insurance issues—it requires the skill of a seasoned professional. Determining the exact nature of the request, which terms and conditions may be altered or amended and in what manner, and which, if any, additional insured endorsement should be requested/attached is not child’s play. Further, if any of these things are done improperly, the agency may find itself in the middle of an E&O case with perhaps one of its most inexperienced employees in the position to make or break the case.

From an efficiency standpoint, it is typically best if the person who receives the certificate request completes the task. When work is handed off to another person, the possibility of an error increases exponentially. Timely issuance of certificates is a huge service issue for any agency, and if the transaction can be completed in real time, without having it bounced from person to person, the insured, the certificate holder, and the agency all benefit.

It is always important to use the proper certificate when processing a request and to make sure your system uses the most recent edition of the form. ACORD currently provides the forms listed below, but these may change and the carrier may sometimes have their own form:

- ACORD 25 Certificate of Liability Insurance
- ACORD 26 Certificate of Property Insurance
- ACORD 27 Evidence of Property Insurance
- ACORD 28 Certificate of Commercial Property Insurance

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Before ACORD certificates came into being, the way to provide evidence of insurance was to issue a “true and certified copy” of the entire insurance policy to a party of interest. An ACORD certificate really just a snapshot of the declarations page of the client’s policies on the day the certificate is issued. There is no warranty that coverage will remain the same in the future only that it was in effect at the time the certificate was issued. A certificate was never intended to provide to the certificate holder, as the certified copy of the policy did, all of the terms and conditions of the insurance policies issued to the insured. An agency’s attempt to capture various parts of their client’s insurance policies and embed them in a certificate may put the agency in a bad position if the certificate is relied on by anyone as a coverage document.

Unlike the certificates, the Evidence of Property Insurance form does confer rights on the holder, specifically the right to receive notice of cancellation. It should be used whenever you need to certify to a lien holder, loss payee, or mortgagee, who has an insurable interest in property, the existence of property insurance. When sent to the insurer, an endorsement to the policy should always be issued if the holder has not been previously added to the policy.

Some third party vendors now offer online certificate issuance that can be accessed by both the agency and the insured. The CSR initially sets up a “master” certificate with the vendor, similar to what is done in the agency management system. The insured is then given a password and access to the website. This can be a real service to a construction client who has need of many certificates that are of a relatively simple nature (i.e., no special wording, unusual endorsements, etc.) However, it does not relieve the agency of a potential E&O liability. In fact, it may be a step in the wrong direction if the agency doesn’t have proper procedures in place to audit the certificates as issued by the insured and take appropriate steps in a timely fashion to address any problems.

Years ago, some insurance companies began to refuse to accept the delivery of certificates of insurance from agencies, presumably to limit their exposure to loss should a certificate be issued incorrectly by the agency or in an effort to avoid responsibility for giving notices and liability for notices not given. While some carriers are opposed to receiving the certificates, it is generally appropriate for agencies to transmit copies of ALL certificates and other evidences of insurance must be transmitted to the carrier in a timely manner anyway. If returned by the company, the agency may want to transmit them back again and document the file accordingly. The agency can include an explanation that it is fulfilling its responsibility to the carrier to keep them apprised of all information pertaining to an insured.

One of the questions that nearly always comes up in regard to certificate issuance is:

“Do I have to show a large umbrella or excess policy if the certificate holder’s request could be complied with by just showing the primary limits?”

The answer, in short, is no. In fact, some of your customers may explicitly request that you not show a certificate holder that they carry a very high liability limit, for fear the asking price in

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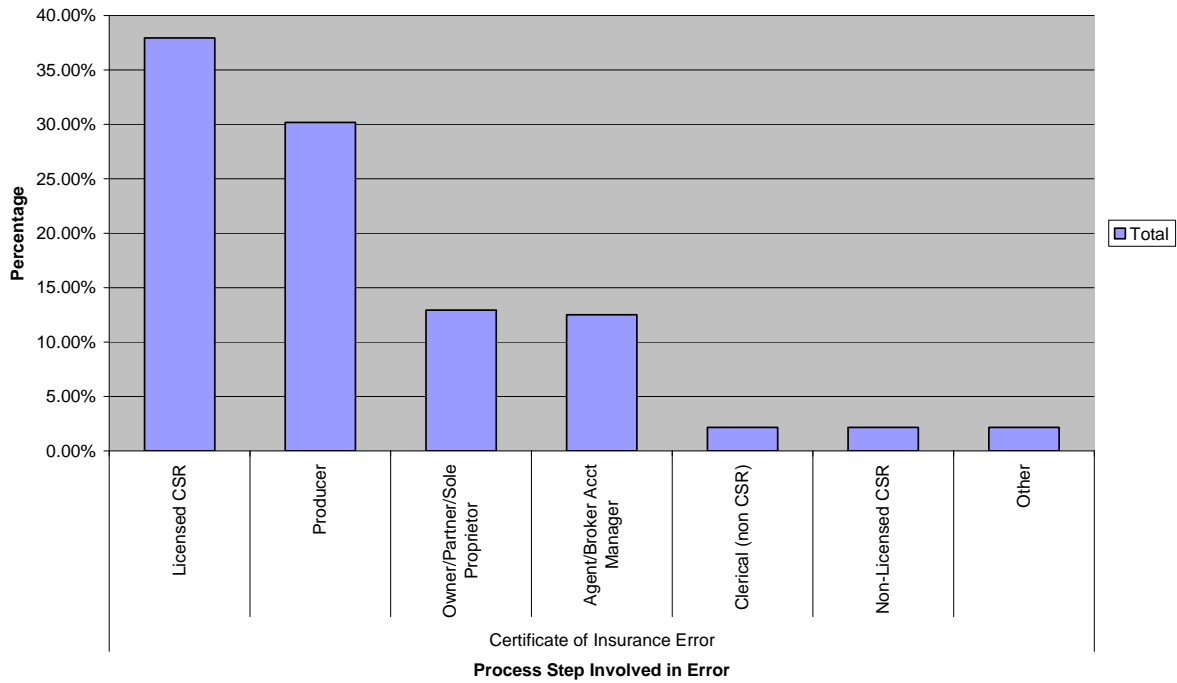
any subsequent lawsuit might be higher based solely on that fact and not the merits of the suit itself. So, if you have a client with a \$1,000,000 primary limit and a \$5,000,000 umbrella or excess policy, you need not put the umbrella or excess policy on any certificate when the primary limit satisfies the certificate holder's request.

What you must do, however, is accurately represent any policies you do include on a certificate. For example, if an insured has a \$1,000,000 underlying policy and a \$5,000,000 excess policy, and the certificate holder requires evidence of a \$2,000,000 limit, you must then disclose the entire \$5,000,000 excess policy in order to comply with the request. It would be inaccurate and improper to show the excess limit at \$1,000,000 since that is not what the policy shows. This kind of a misrepresentation should be avoided to prevent allegations of fraud. Therefore entering multiple master certificates in your agency management system may be necessary, but it is worth the effort.

National Claims Statistic: About 4% of E&O claims come from errors made involving certificates. While that frequency number may seem small, certificate claims generally have above average severity associated with them. Certificate claims must often involve licensed CSRs (38%) and producers (30%).

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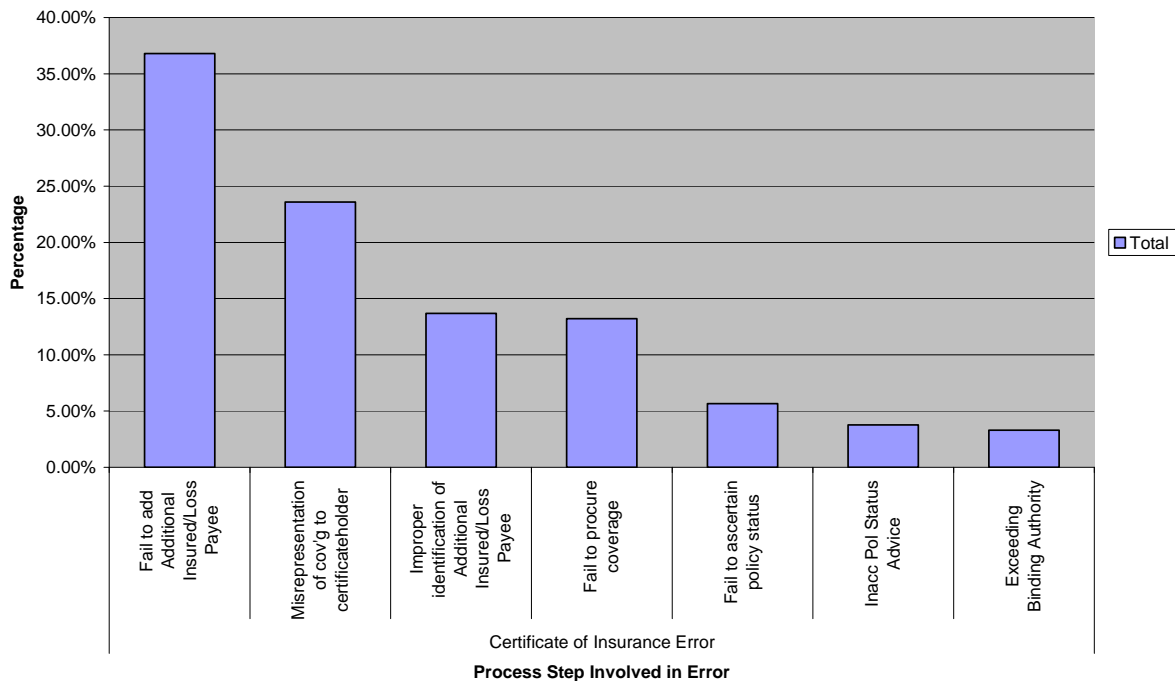
National Agent E&O Claims Frequency - Top Five Employees Evolved in Certificate of Insurance Claims (Jan. '04 to Dec. '06)



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National Agent E&O Claims Frequency - Top 7 Errors Made on Certificate of Insurance Claims
(Jan. '04 to Dec. '06)



Types of Typical E&O Claims

- ✓ Failure to request Additional Insured or other appropriate endorsements from the carrier when it is indicated on the certificate
- ✓ Improper identification of additional insured/loss payee
- ✓ Misrepresentation of coverage to certificate holder
- ✓ Failure to notify a certificate holder when coverage is cancelled, as indicated on an altered certificate
- ✓ Exceeding the agency's authority to issue and/or sign certificates
- ✓ Using non-ACORD certificates that extend coverage beyond that intended by the insurer
- ✓ Attaching Additional Insured endorsements that are not available in the marketplace

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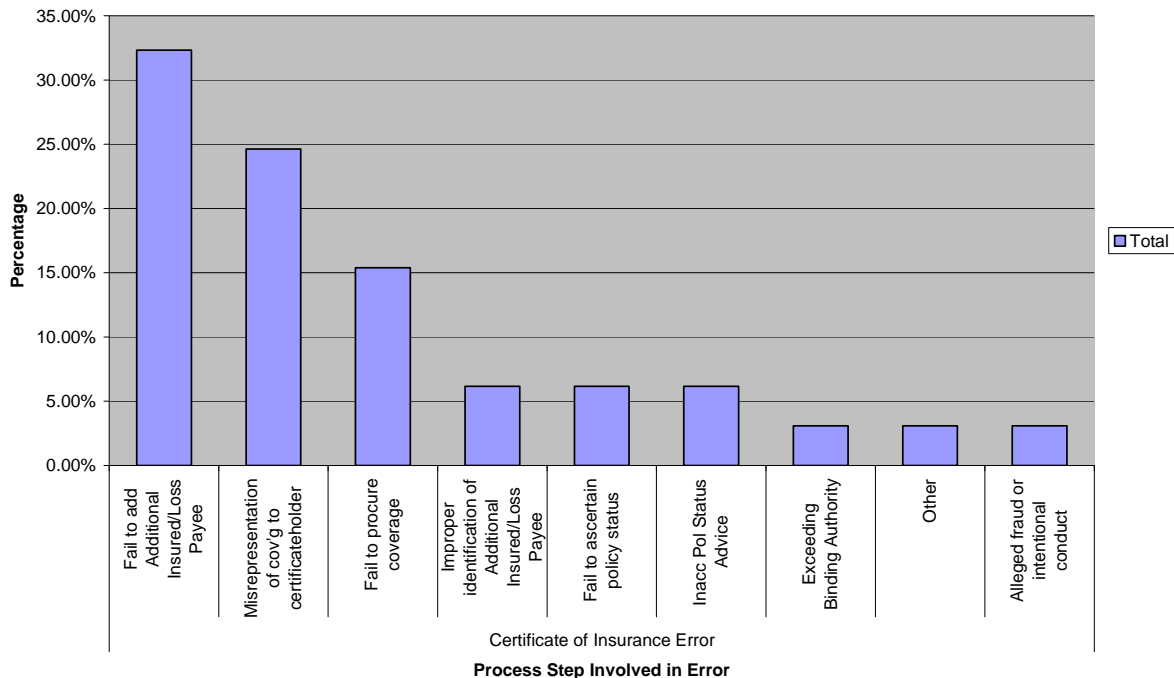
- ✓ Altering the wording on an Additional Insured endorsement
- ✓ Misrepresenting policy terms in preparing certificates

What the Producer Can Do

It would be highly unusual for a producer to be involved in issuing certificates of insurance. However, producers often help to communicate to clients the consequences of complying with or not complying with a certificate holder's request for unusual or non-standard wording or coverage forms that are not generally available in the marketplace.

National Claims Statistic: Producers are twice as likely as CSRs to misrepresent coverage on a certificate. Failing to add an additional insured or loss payee is the most frequent error made in the handling of certificates.

National Agent E&O Claims Frequency - Top 7 Errors by Producers on Certificate of Insurance Claims (Jan. '04 to Dec. '06)



- ✓ State what the agency can and can't do in the issuance of certificates.

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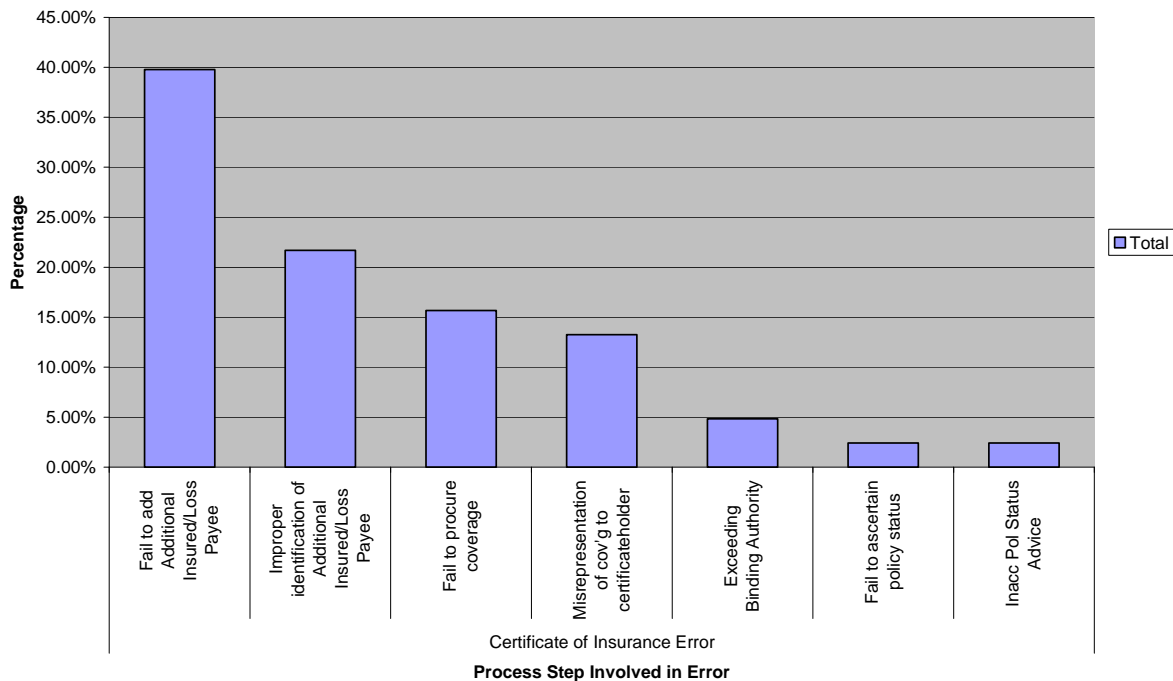
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- ✓ When conducting a pre-renewal meeting, provide a current list of certificate holders and ask the insured to provide an updated list
- ✓ Advise the insured all certificates will be issued only on forms and with wording acceptable to the insurance company, including when requests for unusual or non-standard wording
- ✓ Alert the insured to the fact that there is a charge for Additional Insured endorsements and how that charge will be determined
- ✓ Don't volunteer to review contracts on behalf of the insured—instruct them to have this done by their attorney and to forward only the insurance requirements section to the agency for processing certificates

What the CSR Can Do

One of the most important functions performed by a CSR is the proper and timely issuance of certificates of insurance. Since information in the agency's database "pulls" to the certificate (and other ACORD forms), it is vitally important that the coverage information be accurate.

National Agent E&O Claims Frequency - Top 7 Errors by Licensed CSR on Certificate of Insurance Claims (Jan. '04 to Dec. '06)



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- ✓ Request appropriate Additional Insured or other endorsements the day a certificate/evidence is issued, and if you are not authorized to bind such coverage, do not include it on the certificate
- ✓ Always send an entire certificate (including the second page, which contains additional disclaimer language) to certificate holders
- ✓ Use care when setting up “master” certificates in your agency’s management system—in some cases you will have to create multiple masters, depending on the situation
- ✓ Use the proper ACORD form and edition date or other form authorized by the carrier
- ✓ If you use non-ACORD forms, always get approval from the insurance carrier
- ✓ Do not alter the wording on an ACORD certificate without the written authorization of the insurance company(ies)

- ✓ Be sure you are an authorized representative for every insurance company listed on the certificate—it may be necessary to issue or have issued more than one certificate, and you should not issue certificates for carriers the agency is not authorized to represent
- ✓ Document who requested the certificate and how it was transmitted
- ✓ Comply with any company requests to provide a list of certificates issued when operating under a Blanket Additional Insured endorsement
- ✓ Do not use a certificate to reiterate policy wording
- ✓ Send copies of any certificates issued to all the insurance companies the day they are issued

What Management Can Do

- ✓ Prepare a matrix of what each carrier will permit the agency to do when preparing certificates (e.g., number of days notice of cancellation, primary and contributory wording, waiver of subrogation, etc.) and distribute it to all staff members who

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prepare certificates—and see that it is updated periodically as carrier practices/requirements change

- ✓ Monitor certificates to make sure employees are verifying with the company if client requests modifications to the certificate
- ✓ Review who currently issues certificates and make sure they are all properly trained and experienced
- ✓ Advise all of your insurance companies that certificates will be sent every time they are issued and that your E&O carrier and your internal procedures require that they not be returned to you by the company, and seek revisions to any appointment contracts that are contrary to this
- ✓ Obtain a letter from any Excess and Surplus Lines Broker or Managing General Agent every year giving authorization for the agency to issue certificates on its behalf

- ✓ Carefully review any agreements signed with third party vendors to provide your insured with online access to certificates
- ✓ Periodically run a report by CSR of all certificates issued for a specific period of time and randomly check to see they are accurate and in accordance with the agency's written authority
- ✓ Establish a written procedure for handling certificates of insurance and Additional Insured endorsements and be sure that staff is trained on it

TECHNOLOGY AND AGENCY AUTOMATION

Every agency uses technology to some degree. While some agencies are operating in a nearly paperless environment, others have continued to maintain paper files. Technology, in and of itself, does not create E&O exposures, but there are some additional steps that should be taken to ensure that the agency is using technology appropriately and not creating additional problems that could result in an E&O claim.

When we speak of technology and automation, there are many devices, systems, communication methods and issues that should be addressed:

- ✓ The agency's management information system (MIS), including remote access via laptop computer
- ✓ Admissibility of electronic records
- ✓ Fax machines
- ✓ Cell phones
- ✓ Voice mail
- ✓ E-mail and instant messages
- ✓ Personal digital assistants (PDAs)
- ✓ Agency websites
- ✓ Upload and Download
- ✓ Carrier proprietary systems
- ✓ Electronic delivery of insurance policies
- ✓ Privacy and security

Technology has the ability to transform agency operations and assist in the effort to reduce E&O claims, but only if it is used properly and with an abundance of caution of what could go wrong. Automation is designed to increase our efficiency and productivity, which increases the amount of time every member of the agency's staff can spend giving counsel and advice to customers.

The Agency Management System (MIS)

When it comes to full-function agency management systems, there just are not that many choices and the systems that are available offer most of the same options for the agency in terms of functionality:

- ✓ Customer detail
- ✓ Policy detail
- ✓ Coverage detail
- ✓ Suspense/activities
- ✓ Accounting

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- ✓ Claims
- ✓ Form letters and document management
- ✓ Prospect information

Therefore, the question is not which system to choose or to use, but rather how the agency will manage its automated processes.

Big “I” Member Benefit:

The Agents Council for Technology (ACT) is a partnership of independent agents, companies, technology vendors, user groups, and associations dedicated to enhancing the use of technology and improved work flows within the Independent Agency System. It offers a plethora of information and tools to help agents understand technology related issues. The below listed guide will supplement the next several topics covered.

[Best Practices Guide to Agency Electronic Information Management](#) - This guide is an essential tool for independent agencies and brokers making the transition to the most modern techniques of information management. Agents will find this interactive guide to be practical and written from their perspective. It will help them take the necessary steps to become paper-less and to manage all of the different kinds of media—both electronic and paper—that agencies and brokers must file and retrieve today. To access the paper, visit www.independentagent.com/ACT.

Paper or Plastic?

Many agencies exist with one foot in the automated world and another still clinging to their paper files. We sometimes wonder why it is that our staff members seem to be more overwhelmed than ever, and yet they have access to all these wonderful automated tools. The answer could be that we are asking them to do duplicative work. If you use an MIS properly along with a scanning or imaging system, you do not need to maintain a paper file. Keep in mind that applicable laws should be reviewed before originals or copies of documents are not kept, and any documents discarded should be destroyed in accordance with the requirements applicable to documents with the information they contain, which may require shredding. In fact, from an E&O standpoint, it is extremely dangerous from a consistency standpoint to keep two sets of files since as it is highly unlikely that each will be a mirror image of the other. Inconsistent file management will beg the question—which record is the correct one? Don't

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lose sight of the fact that different documents in different files is an issue, but incomplete or missing documents can be extremely damaging from a litigation standpoint. Duplicative record keeping may lead to no complete file and the problematic missing documents. So, the first step toward reducing E&O losses is deciding which type of file you will use, and then consistently documenting it. The file is the file, whether electronic or paper, but not both. You simply must choose.

Electronic File Management

If you've chosen to really use your MIS, you realize that one of its most undervalued functions is to provide documentation should the agency ever be involved in an E&O claim. The heart of most agency management systems is their use of "activities" which provides the story of everything that transpired on an account. The more detail that can be provided the better, since lack of documentation has often made it more difficult to successfully fight E&O claims. When using the system to memorialize conversations with customers, company representatives, and others, it is invaluable to include full details for every transaction, including who initiated the contact, how a request was made, what the outcome was, and the like. The purpose of using an MIS is for efficiency

in management and ease of output, not input. In other words, we want to use the system to make it as easy as possible for anyone in the agency to find what is needed when it is needed including after the fact when questions may arise, not eliminate keystrokes on the front end. Anyone who needs to step in and look at the chronology on a transaction should be able to do so without contacting the person who handled it. The file and the agency's database should be complete.

The method for entering activities in the system should be standardized and spelled out in the agency's procedures manual. Some people like to use abbreviations and their own system of shorthand. They are focused on the input and trying to save themselves entry time, when they should be focused on output and the ability of another person, who was not involved in the transaction, to decipher it at some point in the future. Therefore, the method for entering activities should be consistent and if abbreviations are used, they should be standardized for everyone in the agency.

Imagine looking at a customer's electronic file and finding the following entry:

LM for ins re: BI loss & if the O/P was req a SR1 for DOL 4/24

To the person who entered the information, this might make perfect sense ("Left message for the insured regarding the Bodily Injury loss and if the other party was required to complete a state financial responsibility form for the loss on 4/24/2007")—although with the passage of

time it might be difficult for that person to remember to what they were referring. To the rest of us, it's gibberish, and we can think of at least three different interpretations for the abbreviation 'BI'. Clarity and constancy will save time, increase productivity and provide more useful records if questions arise. Imagine having someone try and explain that to the prosecuting attorney, especially if the employee who wrote it left the agency.

The agency management system is a transactionally-driven system. When it comes to customers and policies, there are only so many different types of transactions that can be performed. We can:

- ✓ Add coverage
- ✓ Delete coverage
- ✓ Open or close a claim file
- ✓ Issue documents such as ID cards, binders and certificates
- ✓ Renew, rewrite or reinstate policies
- ✓ Cancel or non-renew policies

When documenting activities in the system, it is important to keep the transaction in mind, rather than the delivery method of the communication. Thus, if you are making a policy change, you would typically create the activity using POLICY CHANGE (or other appropriate abbreviation based on your system) and then document the event (for example, "received a call from Joe Smith to add a new vehicle..."). The activity would not be PHONE IN, since that would not allow someone else to easily find the transaction since they wouldn't know how the agency had been notified of the change. Activities are usually best recorded based on the type of transaction to which they pertain.

Suspense and Follow Up

Another feature of an MIS is to "suspend" items that require future action. In the paper world, we used calendars or diaries for this purpose, but in an automated environment, we use the system and only the system to create an electronic reminder of what needs to be completed. Also, there needs to be a procedure in place to review an employee's suspense items when they come up even if that person is not at work that day since some tasks are critical to keeping a customer's coverage in force. Reviewing suspense logs allows managers to monitor employee workload and performance.

Scanning and Imaging

One of the biggest technological advances that has the real potential to increase the efficiency of agency personnel, improve productivity, and reduce expenses is the use of scanning and imaging for document management. Most agency management systems have this capability, or software and hardware can be purchased from third party vendors that will integrate with the agency's MIS.

One of the most important things to remember when using a scanning solution is that there is a huge difference between data and an image. Some of the information received in an agency needs to be recorded in the customer's electronic file in a specific data field. The data fields allow the agency to perform searches and run reports. Remember that retrieval of information when needed is one of the most compelling reasons to be automated. An image, on the other hand, is a static electronic document and although some document management systems will allow you to redact, highlight, or otherwise manipulate the image, it still remains just a photograph of what was put on paper. The inability of a person within the agency to actually change a document that has been scanned into the system so that it retains its integrity in the place of the original will be a critical component of E&O loss control.

When using scanning and imaging, it is important that all documents be attached to a specific customer file, preferably at the activity level. In other words, any images should be attached to the transaction to which they pertain. Scanning should be done as soon possible after the transaction has been processed in order to keep the electronic file up to date. Many agencies have come to the conclusion that paper should be scanned on the "back end" once it has been processed, rather than on the front end (i.e., when it comes in the door). This ensures that only necessary items are retained in the agency's electronic files. You should continue to date stamp all mail received in your office—but remember to do it on the front of the document since you sometimes do not scan the blank backs of items.

Once a piece of paper has been scanned and attached to a customer or other electronic file, it typically can be discarded or shredded (to the extent permitted by applicable law and your agency policy). For compliance with the privacy laws, it is important to properly dispose of any documents that contain non-public personal or private information belonging to a customer, typically by shredding.

Big “I” Member Benefit:

A premier benefit of membership to the Big “I” is access to the Legal Advocacy section of the website which is brought to you by IIABA’s Office of the General Counsel (“OGC”). The OGC handles agency/broker member and state association requests on a broad range of legal and business issues, including reviews of and advocacy concerning contracts addressing agency relationships with carriers, Big “I” trademark use and infringement, antitrust, and federal laws and regulations affecting the insurance industry. The OGC also prepares memoranda and FAQs to assist members in complying with the complex legal requirements of federal laws and regulations that affect their agency and brokerage businesses.

To obtain further information about the privacy laws mentioned above visit www.independentagent.com under Legal Advocacy, Memoranda and FAQs, and reviewing the materials on Gramm-Leach-Bliley and HIPAA.

Archiving and Back Up

Obviously, without paper files we become wholly dependent on our MIS. More than ever, it is mission critical that a daily backup be performed and that the back-up be kept off the premises by key personnel or through the vendor managing your network. To protect the customer’s information, the backup should be encrypted lest it fall into the wrong hands. In the event of a disaster, agency personnel can be up and running using alternate servers in an unaffected location in no time as long as they have access to their data. Also, if paper is to be shredded, you want to make sure that you have everything that has been scanned into the system backed up prior to disposal.

What the Producer Can Do

- ✓ Learn to use and rely on the system as the primary file for a prospect or customer and document all files consistently and completely
- ✓ Create and maintain thorough documentation of all transactions in the customer’s electronic file

What the CSR Can Do

- ✓ Properly document all transactions in the customer's electronic file if that is how all records are to be kept
- ✓ Keep the agency's database up to date
- ✓ Use the agency's MIS as the primary suspense system for items requiring further action
- ✓ Use system activities properly and in accordance with the agency's procedures
- ✓ Review renewal/expiration lists at least once each week to ensure continuous coverage

What Management Can Do

- ✓ Provide a culture supportive of technology
- ✓ Provide remote access to the agency's management system to producers and others who are frequently out of the office in a secure way that protects non-public customer information
- ✓ Ensure the security of your agency's management system, its data, and any documents that have been stored electronically
- ✓ Establish a procedure to verify the accuracy and timeliness of all data input by agency personnel

Management should run reports to ensure the consistent application of technology within the agency and to monitor for adherence to procedures. While each agency management system is different, reports that should routinely be run typically include:

- ✓ Transaction/activity log
- ✓ Open suspense
- ✓ Exception reports
- ✓ Expiration lists
- ✓ Communication logs with carriers

Admissibility of Electronic Records

Some people confuse the fact that we may have to produce documents in the event of an E&O claim with whether we must retain originals of the documents in our electronic systems. When

you receive a request for production of documents in a legal matter, you must provide what you have that is responsive to the request. Typically that will include information about certain things in whatever form you have them in but may vary by the specific content of the request.

Typically it is a lack of documentation or content of the documentation that increases the risk of an adverse outcome in an E&O claim, not whether the records have been kept in electronic or paper form (unless applicable laws require that it be kept in a specific way and it is not). What is important, however, is that there be a consistent process in place with records of all transactions, and it may be best managed with an electronic file from an automated agency. Electronic records may be perceived as more difficult to alter or erase than their paper counterparts.

Your attorney can assist you in determining what the rules of evidence are in your jurisdiction and what the current status is of admissibility of electronic files. You should follow their advice.

Fax Machines

Most agency management systems provide the ability to fax items to and from an individual's desktop. Many agencies believe this as the preferred method, as opposed to standalone fax machines. We all know the problems that can arise using standalone equipment:

- ✓ Not all pages received are distributed to the right person
- ✓ Incoming faxes are not distributed in a timely manner
- ✓ Outgoing faxes require a person to leave his or her desk
- ✓ The date or time stamp on the fax is incorrect
- ✓ Outgoing faxes of a sensitive nature cannot be controlled
- ✓ The logs of fax transmissions are not archived or preserved

If it is not possible or practical in your agency to have faxes sent and received from the individual workstation, then you should use caution to eliminate as many of the pitfalls shown above as possible.

All outgoing faxes should have a confidentiality statement printed on them. An example is:

This transmission contains information that may be confidential or privileged, and is intended only for the recipient identified above. If you received this transmission in error, please notify the sender immediately, delete all copies, and be aware that any disclosure, copying, distribution or use of the contents of this transmission is strictly prohibited. Also, for your protection, coverage cannot be bound or changed via voice mail, e-mail, fax, or online via the agency's website, and is not effective until confirmed directly with a licensed agent.

Big “I” Member Benefit:

A premier benefit of membership to the Big “I” is access to the Legal Advocacy section of the website which is brought to you by IIABA’s Office of the General Counsel (“OGC”).

To obtain further information about the federal law governing faxes, there is information on the Junk Fax Prevention Act of 2005 on www.independentagent.com under Legal Advocacy, Memoranda & FAQs

Cell Phones

Now that cell phones are standard issue with so many in the business world, we must find a way to deal with any E&O concerns presented by their use. The primary issue with the use of cell phones is documentation. When conversations take place on a cell phone, it is important to document the MIS. Whenever a conversation takes place with an insured, a prospect, an underwriter, or anyone else that relates to a specific account or transaction, it is important to document the MIS just as would happen if the conversation took place in the office.

As soon as practical, you need to create a record of the phone call. This can be accomplished by calling your own voice mail and then entering the information in the system when you next have access to it, or you can simply call someone who does have access and ask that they document the file. Or, if you take notes on the call, you can use them to enter the details at your next access to the MIS. For E&O purposes, it is preferred for the person who actually had the conversation to do the documentation as close in time as possible before memories fade. It is important to confirm any significant conversations in writing as soon as possible to avoid misunderstandings.

Voice Mail

More and more agencies are going to direct dial phones and personal voice mail boxes for all agency personnel. This is a convenience most of us welcome, but can have E&O implications.

Many agencies like their staff to change their outgoing message every day so callers immediately know if they are in the office or not. Even if that is not done, callers can be instructed what to do if they need immediate assistance which could arise if someone is in the

office but unavailable due to a meeting. Many agencies also ask their staff to include a disclaimer on their outgoing voice mail message about not being able to bind or change coverages by voice mail message. While it can't be too long, it's important that your outgoing message be informative. An example of a possible outgoing message to use is:

"You have reached the voice mail of Joe Smith on Monday, April 23, 2007. I will be out of the office all day. Please leave a detailed message, and I will return your call as soon as possible. If you require immediate assistance, please press 0, followed by the pound key and you will be transferred to Mary Jones who can help you. For your protection, coverage cannot be bound or changed via voice mail, e-mail, fax, or online via the agency's website, and is not effective until confirmed directly with a licensed agent. Thank you for calling and have a great day."

E-mail and Instant Messages

Certainly one of the greatest things to enhance the efficiency and productivity of every agency is the increased use of e-mail. E-mail is permanent, and as such can be useful as an E&O loss control tool...or it can be problematic when it has not been used properly. Like voice mails, agencies may want to consider the best approach for including appropriate customer correspondence from e-mail messages into the customer file on the MIS for documentation purposes.

It's important to remember what e-mail replaced—mail, not the telephone. Some people take great license when using e-mail and suspend all the formalities they would have used when writing a letter. However, it is important to remember that e-mail can be recovered and produced even when the user has deleted it, so it should be treated like any other business communication tool.

Many agencies require that all e-mail contain a "signature" that gives your name, the agency's name, mailing address, phone and fax numbers, and other appropriate contact information. In addition, you can include a paragraph that deals with privacy and the use of your e-mail messages. An example is:

This transmission contains information that may be confidential or privileged, and is intended only for the recipient identified above. If you received this transmission in error, please notify the sender immediately, delete all copies, and be aware that any disclosure, copying, distribution or use of the contents of this transmission is strictly prohibited. Also, for your protection, coverage cannot be bound or changed via voice mail, e-mail, fax, or online via the agency's website, and is not effective until confirmed directly with a licensed agent.

It is important for all agency personnel to be trained in the use of e-mail tools required by the agency to be used, such as auto-reply functions for when you do not have access to e-mail so

those contacting you are notified of who they can contact for assistance in your absence. This helps manage your customer's expectations and needs. In some agencies, it is required that e-mail is automatically forwarded to another person for handling when someone is absent.

Unlike e-mail, Instant Messages (IM) may not be permanent in a system on their own, but records of them can be kept. Unless you know that any IMs you create can be attached to a customer's electronic file, you should avoid using them for business correspondence unless there is a process for them to be included in the file. If they are used, you should document any IM "conversation" the same way you would a telephone call.

Personal Digital Assistants (PDA)

In an effort to reduce the number of devices we carry, many people have turned to PDAs, which combine the power of a computer with a telephone. E-mail can be received and sent from such devices, documents can be prepared and revised, and Internet connections are readily available. As we have stated with other types of communication methods, it is important that any electronic correspondence that relates to a customer's account be protected from the risk of non-public information being shared as well as captured in the agency's management system. Therefore, standalone devices that are not networked to the agency's system represent an E&O hazard and should be used with a procedure in place to capture any customer information and put it in the agency's database, the same as you would with a cell phone conversation.

Big "I" Member Benefit:

The Agents Council for Technology (ACT) offers **Protecting Agency Customer Information from Identity Theft** a report that discusses key issues agencies must tackle to safeguard private customer information, prevent identity theft, implement an effective security policy, and protect agency data both while at rest in the agency's systems as well as in transit to and from the agency. To access the paper, visit www.independentagent.com/ACT.

Agency Websites

By now, most agencies have established a presence on the Internet with a website. Some agencies have nothing more than an electronic billboard that gives basic information about the agency; others have fully interactive websites that allow a customer to get a quote, access their account information, or complete routine transactions such as policy changes and certificates of insurance. Insurance companies are also allowing customer access to billing, claims and other policy information. In between, there are “view only” websites that will allow a customer to see their policy details, but not make any changes or request further information.

The first step for an agency is to decide exactly what information will be provided to customers with an eye towards any potential E&O situations that could be created. Some agencies use their website to provide more convenient service to your customers without having to hire additional staff and incur the expense of being open all day, every day by offering access to certain information and service 24/7.

In order to access the agency’s website for customer specific information, each customer should be provided with a unique logon and password. It also goes without saying that any transactions done on the agency’s website must be in a secure format. Many agencies have an IT person on staff, but ensuring the security of your website may require the services of an outside professional.

As more and more customers become comfortable with accessing information in this manner, the industry may move much more quickly to accommodate them. This has the potential to create additional E&O concerns for the agency.

A prominent disclaimer should be posted on every agency website to advise any prospect or customer who visits that entering information on the website does not create a policy of insurance and that no such contract exists unless and until it is confirmed by the agency. Be sure to indicate how that confirmation will be completed, that is, via e-mail, mail, or some other method. An example is:

Statements on this web site as to policies and coverages provide general information only. This information is not an offer to sell insurance. Insurance coverage cannot be bound or changed via submission of any online form/application provide on this site or otherwise, e-mail, voice mail or facsimile. No binder, insurance policy, change, addition, and/or deletion to insurance coverage goes into effect unless and until confirmed directly by a licensed agent. Any proposal of insurance we may present to you will be based upon the information you provide to us via this online form/application and/or in other communications with us. Please contact our office at [insert phone number] to discuss specific coverage details and your insurance needs. All coverages are subject to the terms, conditions and exclusions of the actual policy issued.

Not all policies or coverages are available in every state. Information provided on this site does not constitute professional advice; if you have legal, tax or financial planning questions, you should contact an appropriate professional. Any hypertext links to other sites are provided as a convenience only; we have no control over those sites and do not endorse or guarantee any information provided by those sites.

In addition, agencies should review their websites periodically to be sure that the content is up-to-date. It is also important to post and provide easy access to your website privacy policy and terms of use.

Upload and Download

Upload and download held the promise of true paperless communication between the agency and its carrier partners and in many ways it has delivered some of the efficiency gains that were promised. However, the gains were not secured without a price in terms of E&O exposures.

Most agencies receive information via download for personal lines, and more and more are receiving commercial lines data from their carriers in a download. In the past, upload and download were completed using an industry-wide telecommunications portal which was presumably able to communicate in the various “languages” spoken by the agency’s management system and the carrier’s proprietary system. With the increased use of the Internet and its ability to transmit data at speeds much faster than traditional dial-up lines, most upload and download is now completed using the Internet and some kind of high-speed connection, such as cable, satellite or a T-1 line.

Ideally, what happens is that underwriting and other information is transmitted (uploaded) to the carrier via the agency’s MIS or the carrier’s system that resides on the agency’s computer. Then, when a transaction is completed by the insurance company, information is downloaded into the agency’s database. In some cases, this is where some E&O risk resides. Accuracy of data needs to be a priority. Some of the potential problems with carrier download are:

- ✓ Inconsistent entry of data—each carrier determines how much and what type of data to transmit via download, which can result in incomplete information in the agency’s electronic files
- ✓ Errors in download transmissions—information in the agency’s database can be overwritten by the carrier’s data, be put in the wrong field, or even attached to the wrong customer

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- ✓ No paper—when a carrier “turns off the paper” (which it may if download is to achieve its efficiency and productivity gains), error will not be caught if the agency does not check transactions the way they did when they received a hard copy

Two examples of problems with download are in Business Owner Policies (BOP) and Farm. Some agency management systems do not include the BOP or Farm ACORD applications. Likewise, some companies do not use these applications, favoring the Commercial Package Policy set of applications or their own proprietary forms. When data is downloaded by the carrier in these two lines of business, it may not populate the proper application in the agency’s MIS.

It is important that someone in the agency be responsible for auditing downloads to ensure accuracy of information. In some cases, the carrier is known to have download problems, so it would be appropriate to audit each transaction. Other companies have worked out the kinks in their system and the download might only have to be audited on a random basis. Ultimately, the quality of the agency’s database is of utmost concern and the agency may decide not to implement downloads with carriers that have not worked the bugs out of their systems as it may require the agency to constantly go in and manually override what has been downloaded.

Carrier Proprietary Systems

While automation has the potential to make everyone’s job easier, it also has the opportunity to complicate what should otherwise be routine transactions.

In the paper world, there was only one way to process an endorsement: we sent a form or memo to the company asking them to make the change. In our newly automated world, there are no less than five ways to process a policy change:

- ✓ Enter data directly into the carrier’s proprietary system
- ✓ Send an e-mail from the carrier’s proprietary system
- ✓ Send a Policy Change Request directly from the agency’s MIS
- ✓ Send an e-mail from the agency’s MIS
- ✓ Fax a request or Policy Change Request to the carrier

Add to this mix the fact that every company is different and has its own internal method of dealing with every request. If there is an error made when entering information in the carrier’s system, some systems will notify the agency via e-mail, others will provide an error list, and others will require that the entire transaction be deleted and re-entered.

What are the implications for the agency? Aside from having to learn a variety of systems to process work, carrier proprietary systems require separate procedures for each situation and holds the potential for an E&O claim if something is not processed in the proper manner.

Data entered in the carrier's proprietary system is not automatically entered in the customer's electronic file. This requires duplicate entry into the agency's management system, at least to create activities and a suspense for receipt of the endorsement. When an agency is totally reliant on its customer database, dual entry is required when the whole purpose of automation was to eliminate such wasted steps.

Electronic Delivery of Insurance Policies

Imagine how much money is spent each year by companies and agencies printing and mailing policies to our customers. Electronic delivery of policies to the agency and/or the insured has the potential to reduce the transaction costs for an insurer by a huge amount and some companies are already pursuing this option by either sending a CD or e-mailing the policy to the agency. But does it have any E&O ramifications?

Certainly if a prospect completes an application online, receives a quote, and then wishes to secure coverage, that person would be agreeable to receiving an electronic copy of a policy. Many insurance companies are conducting business this way today. But what about your customers who have purchased insurance the "old fashioned" way?

Depending on who your customers are, some would give a resounding "yes" when asked if they would like to get an electronic copy of their policy. Some online companies actually charge the insured extra if they elect to receive a paper copy rather than download a copy of their policy from the company's website!

Other customers will still be requesting that we transmit paper documents to them, especially if they don't have the equipment or software necessary to receive electronic documents. Many agencies find that asking each customer which method of policy delivery they prefer works best.

What is important is that no matter which method your customer chooses, you must be able to demonstrate that a complete policy has been delivered to them. If you are sending policies on a CD, you would need to mail it the same as you would a paper copy, and with that as your standard practice, it may require proof of delivery. However, if you are forwarding an electronic policy via e-mail, you may want to ask the insured to acknowledge receipt by e-mail, and this may also require you to change your operating procedures for new and renewal business and policy changes.

Privacy and Security

We live in an era when concerns about privacy and security are heightened due to identity theft, hackers, viruses, and other Internet-related crimes. Because your agency is probably making more use of technology than ever before, your privacy and security needs are also increased.

Information stored in the agency's database must be protected from both internal and external abuse and access. Since many agencies have a complete life, health and employee benefits department, personal information secured in the process of writing those policies should be kept separate from the property and casualty records. At minimum appropriate firewalls should be set up, and in some cases it is advisable to use a completely different management system. Only the people within the agency who have a need to know information should be able to access it.

Big "I" Member Benefit:

The Agents Council for Technology (ACT) offers [ACT HIPAA & Privacy Supplement: A Companion Resource to ACT's Report, "Safeguarding Non-Public Personal Information"](#) a report that includes more detailed information about HIPAA, including security considerations, frequently asked legal questions about HIPAA requirements, and HIPAA's impacts on the workflows of Benefit Departments. To access the paper, visit www.independentagent.com/ACT.

Also available from ACT is [Safeguarding Non-Public Personal Information: A Guide for Independent Agents and Brokers](#) - a report that stresses the importance of agencies' safeguarding the privacy of their customers' private information, such as the medical information governed by HIPAA, and provides agents with practical implementation guidance. To access the paper, visit www.independentagent.com/ACT.

The agency's privacy policy should be distributed to all customers in accordance with state and federal laws, such as Gramm-Leach-Bliley. What's as important as having a policy, however, is seeing to it that everyone in the agency understands it and fully complies with it.

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Passwords used by employees and management should be closely guarded and upon termination or separation of an employee, their password should be disabled to prevent a former employee having access to your system or a carrier's system.

If financial transactions are conducted on the agency's website or you collect credit card information for payment of an insured's policies, the information must be properly secured and disposed of in accordance with applicable laws. Encryption and the use of Secured Socket Layers (SSL) are vital to protecting the insured's information.

Anti-virus software should also be used and constantly updated, to prevent the agency from receiving or transmitting a virus or worm or other disruptive or damaging program or problem. The more information being sent to and received from companies and customers electronically, the more vulnerable our systems become. Keep in mind we probably ask for the same information we did in the paper world, but when we are transmitting it via the Internet or other means, it's a lot easier for the wrong person to get hold of it.

The same issues that arise for electronic communications systems in the office also apply to systems to access the agency database and information remotely, via desktop/laptop or PDA. These agency procedures should factor in security when those tools are used. Also, with so much attention on electronic files, it is important to assure that paper documents are properly secured for access by only those that need to know and handled according to legal requirements.

Big "I" Member Benefit:

To obtain further information about the privacy laws mentioned above visit www.independentagent.com under Legal Advocacy, Memoranda and FAQs, and reviewing the materials on Gramm-Leach-Bliley and HIPAA.

What Management Can Do

- ✓ Educate employees on the proper use of the agency's e-mail, voice mail, fax and other systems
- ✓ Monitor for violations of the agency's technology policies and take swift action for any violations

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- ✓ Train employees on the proper e-mail storage techniques, including the use of folders and attachment to customer files
- ✓ Establish a system to deal with personal voice mail and e-mail boxes when people are out of the office
- ✓ Discuss the issue of confidentiality and improper forwarding of e-mail messages
- ✓ Develop and implement a document retention policy that includes a process for purging e-mail from your system
- ✓ Consider the use of auto-responders when employees will be out of the office for some period of time
- ✓ Establish a written policy for voice mail, e-mail and Internet usage that is consistent with labor and other laws

MISCELLANEOUS E&O ISSUES

Records Retention

Various state and federal laws, as well as business best practices, require maintenance of records such as policy, claim and financial information by an insurance agency. The use of automation allows an agency to store information virtually forever. The problem is, if you store BAD information, it will hurt you in an E&O situation.

The type of coverage provided by the agency may also change the records retention policy. If a great deal of claims-made policies are provided, you may consider keeping files longer than is required by statute. Also, it is generally recommended that commercial lines records be retained longer than those for personal lines coverages.

It is important that an agency NOT rely on an insurance carrier to maintain records. Insurance companies will generally keep records only for the minimum time required by law. Agency records may be kept indefinitely, and having those records may be an important piece of evidence in an E&O case.

What Management Can Do

- ✓ Become familiar with the laws in your state regarding records retention
- ✓ Become familiar with federal laws that pertain to maintenance of records, including new proposed laws that deal with retention of e-mail and instant messages
- ✓ Obtain a records retention guide from your state association or E&O carrier
- ✓ Purge paper and automated files at the appropriate time to ensure compliance with all state and federal laws
- ✓ Establish a written procedure to deal with the retention of customer and other records

Insurer Solvency

State regulations and jurisprudence typically hold an insurance agent responsible to use “due diligence” when placing a customer’s insurance with an insurance company. The concept of “due diligence”, however, varies from state to state.

It is impossible for an agent to predict when a carrier may be seized by a regulator and placed in conservatorship or liquidated, however agents should be alert to the red flags that indicate an insurer may be in financial trouble.

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Ultimately, no one wants to deal with a customer whose claim remains unpaid or unearned premium has not been refunded because the carrier has been placed in receivership. When it turns into an E&O issue, agents must be able to demonstrate that they used sound business practices when deciding to place the customer's business with a particular insurer. In addition, most agency E&O policies have an exclusion for coverage placed with an insurer that has an A.M. Best rating of B or lower.

Types of E&O Losses

- ✓ Placing a customer's coverage with an insurer that subsequently is declared insolvent
- ✓ Not advising an insured of the consequences of placement with a non-admitted insurer when there is an insolvency

What the Producer Can Do

- ✓ Fully inform all customers when quoting a non-admitted carrier or one with known financial problems
- ✓ Comply with all laws and regulations pertaining to business placed with a non-admitted carrier

What the CSR Can Do

- ✓ Fully inform all customers when quoting a non-admitted carrier or one with known financial problems
- ✓ Comply with all laws and regulations pertaining to business placed with a non-admitted carrier

What Management Can Do

- ✓ Regularly monitor the ratings of the insurers used by the agency
- ✓ Establish an agency standard for use of carriers based on their A. M. Best or other rating (B+ or better is required by most agency E&O carriers)

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- ✓ Check the agency's E&O policy to see if there is a restriction for use of carriers whose rating is below a certain level
- ✓ Advise customers when the rating of a company drops below the agency's standard and how or if coverage will be replaced
- ✓ Be aware of the Surplus Lines laws in your state regarding exportation of business to a non-admitted company
- ✓ Frequently monitor your state's list of eligible insurers
- ✓ Run reports to determine if any customers have coverage with an insurer that has been removed from the state's list of eligible insurers
- ✓ Establish a written procedure for dealing with low-rated or non-admitted insurers

Insurance Company Service Centers

Many insurance companies offer agents the option of transferring the responsibility for policyholder service to a company-operated service center. Some insurers even require use of a service center when an agency places personal or small commercial accounts with them. Most companies charge the agency for use of a service center by lowering the commission rate on business so handled.

While many agencies believe service centers provide the same or a better level of service to their customers than they would, there is a loss of contact with the customer that can result in an E&O loss.

Transactions handled in the company's service center may impact other policies the agency writes for the customer that are placed with other insurers. Unless there is a procedure to review all changes handled by the insurance company in the service center, necessary updates may not be made to a customer's other policies, resulting in inadequate or no coverage. Of course, when this kind of scrutiny is in place, the agency may no longer achieve any cost saving by using a service center.

It is also easier for an agency to become complacent when the insurance company handles mid-term policy changes. The company usually doesn't perform the same level of account review that the agency would at renewal, and failure to do so could leave a customer unprotected.

Company service centers should be used with an abundance of caution, since the lack of communication with the customer may cause the agency to overlook an important change in the customer's circumstances.

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Types of E&O Losses

- ✓ Failure to make a necessary policy change
- ✓ Not identifying new exposures

- ✓ Taking an improper action based on an incomplete customer file at the agency level

What Management Can Do

- ✓ Carefully consider all the consequences of using a company service center—and the cost
- ✓ Review all service center contracts and make sure a hold harmless agreement is included for errors made by employees of the company
- ✓ Determine how changes made by the company will be recorded in your agency's management system
- ✓ Establish a written procedure to review all company-initiated transactions for possible impact on the balance of a customer's account

Premium Finance Companies

As a convenience for policyholders, many agencies offer installment payment plans using a premium finance company. When an insured signs a finance agreement, he or she is giving a limited power of attorney to the finance company, who may then cancel the insurance policy if payments are not received in a timely manner. Unlike the Notice of Intent to Cancel issued by a direct bill insurance company when a payment has not been made, the cancellation request sent by a finance company to the insurer will result in policy cancellation and generally only requires 5 days' advance notice to the policyholder.

Most finance companies now allow agents to obtain quotes and complete transactions online. While this is certainly a convenience, it may result in an agency not fully informing customers of the terms and conditions of the finance agreement and getting the insured's signature and agreement to those terms.

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Finance company policy and state law may limit the kinds of transactions that may be financed. Audits, down payments, and fully earned premiums often cannot be placed on a finance contract.

Timely new business and renewal processing is essential when using premium finance agreements, because the down payment and number of monthly installments that must be collected increases as the premium on the policy becomes earned.

Types of E&O Losses

- ✓ Issuing certificates or other evidence of insurance on a policy cancelled by a finance company
- ✓ Not refunding money to the insured following cancellation of a financed policy

What the Producer Can Do

- ✓ Fully disclose all terms of any finance agreement when making a proposal to the insured
- ✓ Inform the insured of the importance of timely payments to the finance company

What the CSR Can Do

- ✓ Obtain the insured's signature on all finance agreements
- ✓ Do not follow up with an insured when notified that a premium finance payment is late
- ✓ Treat all cancellation notices from a finance company as an actual cancellation, and document the customer's file accordingly
- ✓ Promptly process all cancellation endorsements and arrange for a customer refund of any unearned premium

What Management Can Do

- ✓ Deal only with reputable finance companies
- ✓ Become familiar with all state laws and regulations that deal with the use of finance companies

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- ✓ Make sure all agency personnel are fully trained on the use of any online premium finance system
- ✓ Examine all finance company contracts to determine if they include hold harmless agreements or personal indemnity agreements running in favor of the finance company
- ✓ Establish a written procedure to deal with premium finance arrangements

Mergers and Acquisitions

Without a doubt, the number of mergers and acquisitions involving insurance agencies is on the rise. This may be partially due to the fact that many owners did not have a solid perpetuation strategy in place, and found themselves looking at asset disposition, rather than the continuance of their firm.

There are many ways to structure the sale or merger of an agency and legal and tax implications are of the utmost concern. But what about the E&O exposures, and what should be done to limit the potential losses for both parties? If you are thinking of selling, buying, or merging with another agency, the best advice is to seek legal counsel. The contract and agreements between buyer and seller will determine exactly how the E&O liabilities will be handled.

In the case of a true merger, the E&O picture would not really change. The newly formed organization would “inherit” the liabilities from the prior organizations. In some cases, a merger does not involve a physical melding into a new organization, with the merger partners operating somewhat autonomously. This could be an E&O problem if different procedures are being followed in each office. It’s important to determine whose procedures will be followed after the merger, and to quickly implement changes so the enterprise is operating with a single, consistent procedures manual.

When an agency is sold, the buyer often acquires only the firm’s assets, not its liabilities. The seller would continue to insure for its past acts that might give rise to a claim following the sale. The purchase of an Extended Reporting Period (“tail”) from the last E&O insurer will provide protection to the seller. It is important to determine if the policy limit, which may have been impaired by payment of claims, is reinstated during the ERP. The ERP should be for as long a time period as the carrier will make available, often from three to ten years.

If you are acquiring an agency, or a book of business, the most important thing is to perform your due diligence in advance. Ask yourself and the seller some important questions:

- ✓ Why is the agency or book of business up for sale? How long has the owner been seeking a buyer?

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- ✓ What are the technical qualifications of the owners and staff members? What is the firm's historical staff turnover rate? Is it trending upward?
- ✓ What is the agency's reputation in the community? With the insurance companies they represent?
- ✓ Will any of the current owners or staff members be joining your firm?
- ✓ Does the agency have formal, written procedures? Have you reviewed the procedures to see how they compare to your own?
- ✓ What agency management system is the seller using, what is the quality of their database, and how will necessary file information be transferred from their system to yours?
- ✓ What is the likelihood that the business will be retained by your agency? What is the agency's retention rate for the past five years? Is it trending downward?
- ✓ What is the E&O loss experience for the agency? What steps have been taken to eliminate past problems, if any?
- ✓ Is the seller willing/able to obtain E&O coverage for prior acts that may result in an E&O claim? Is the seller willing to indemnify and hold you harmless for any situations created prior to the sale?
- ✓ Will the seller consent to a random file audit (paper and electronic) to determine how the agency's customers have been dealt with in the past?
- ✓ Does your E&O policy include coverage for any firms you acquire? If not, what will be the additional cost to add them to your policy, even on a contingent basis assuming the seller will purchase the ERP?

It is entirely appropriate to meet with the seller's sales and service staff to determine if there are any issues of which you should be aware. Of course, you must respect the privacy of the seller, so use caution and discretion and obtain the consent of the seller to conduct these interviews.

Many times a buyer considers only the financial side of a transaction and calls it due diligence. This can be a recipe for disaster on the E&O front.

If the seller has been attempting to find a buyer for a long time, it could be that the agency's customers have been neglected. Sometimes an owner will run an agency on "auto pilot" pending a sale, and sales and customer service may have suffered.

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Even if the seller has maintained E&O coverage and signed an indemnity and hold harmless agreement, there are still E&O issues for the buyer stemming from accounts now owned by them. In other words, on Day One following the sale and transfer of the accounts, the new owner will be responsible for proper account handling. Even if each account is thoroughly reviewed on renewal, it will take a year to get through every file to determine if it meets your agency standards. If during this time period an insured suffers a loss for which there is no coverage, you can be certain they will not only be looking at what the prior agent did, but also what you have not done to rectify the situation.

Before making a decision to acquire another agency or even just a book of business, you must determine if your current staffing levels are sufficient to absorb the number of new accounts. You will want to match the service level provided to your current customers, and if people are already stretched too thin, you have a problem in the making.

Types of E&O Losses

There really aren't any special E&O losses specific to a merger or acquisition. Anything that could happen in your agency could happen in one you acquire or with which you merge. Therefore, all the loss control recommendations stated in other parts of this manual would apply.

However, if you acquire an agency or book of business that has not been well cared for, you are potentially inheriting an E&O hornet's nest and your liabilities could increase exponentially.

What Management Can Do

- ✓ Hire an attorney and CPA who are familiar with insurance agency mergers and acquisitions
- ✓ Look for trends and be honest with yourself about what you hope to accomplish with the merger/acquisition
- ✓ Perform true due diligence

ESTABLISHING AN E&O LOSS CONTROL PROGRAM

In agencies using Best Practices, the effort to reduce and prevent E&O claims is a proactive one that involves participation at every level.

There are many reasons to devote the time and energy required to implement an E&O loss control program:

- ✓ E&O claims impact the reputation of an agency and can damage its credibility with potential and existing customers
- ✓ Deductibles and Self Insured Retention amounts on agency E&O policies are increasing significantly
- ✓ Adverse loss experience will result in higher premiums and difficulty placing the agency's E&O coverage
- ✓ Steps taken to reduce E&O losses will provide the agency with a solid defense should an E&O claim arise

Ultimately, the best defense against an E&O claim is to provide extraordinary service to your customers. People who have a relationship with their agent are far less likely to take a swipe at them when something goes wrong.

Creating the Program

There are several steps that should be taken to develop and implement an E&O loss control program:

- Step One: Complete a thorough and comprehensive self-audit of the agency's workflows and procedures. Determine which areas require the most immediate attention. Be honest, and encourage everyone in the agency to complete their own self-audit, as the view of management may be vastly different than the people who handle the majority of the agency's day-to-day transactions.
- Step Two: Conduct a file audit on several of the agency's most complex accounts. Treat the situation as if you were a competing agent reviewing the customer's current insurance program. Involve several people who do not actively handle the account. Look for opportunities to improve the customer's insurance program. This will not only lessen E&O exposures, it will raise the level of service you are providing to that customer and may even increase the agency's revenue when cross-selling opportunities are realized.

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- Step Three: Appoint an E&O Improvement Specialist (EOIS) for the agency. The person selected should have an excellent technical background, but also be very familiar with the agency's management system and its internal operations. Work with the person to develop a job description, and keep in mind that to do a good job, he or she will have to reduce his or her current workload in order to fulfill the new job's duties. This person's responsibilities will include:
- ✓ Updating or assisting to create agency procedure manuals
 - ✓ Conducting desk audits of all agency personnel on a regular basis
 - ✓ Handling all E&O claims made against the agency
 - ✓ Training staff members on E&O issues
- Step Four: Discuss any past E&O claims (or near misses) with the EOIS, and have him or her develop an action plan to make any necessary procedural changes that could have prevented the situation.
- Step Five: Hold a staff meeting to introduce the new position, and inform everyone of the importance of sound E&O loss control practices. Advise all staff members that there will be regular desk audits performed by the EOIS, with the goal being to prevent or reduce E&O losses. Give some thought to the rewards (or consequences) for proper adherence to procedures (or non-compliance), and inform your staff of what they can expect.
- Step Six: Work with the EOIS to prepare or update any written procedures. Investigate the sources of procedures manuals and use the samples contained in this manual as a guideline when developing your own (see How to Develop a Procedures Manual below).
- Step Seven: Conduct an in-house training class for all staff members at least once each year, or require attendance at a course put on by your state association or another provider that deals with E&O issues.
- Step Eight: Consider an external E&O Improvement Review (AKA: audit). Sometimes we're simply too close to a problem to solve it. A second set of eyes can really help focus the agency on the things that must be changed in order to prevent or reduce E&O losses. If you chose to hire an outside consultant to conduct an audit, you can expect:
- ✓ A preliminary document that will request basic information about the agency, including past E&O claims, prior to an on-site visit
 - ✓ A one- or two-day visit by the auditor who will speak with owners/principals, producers and CSRs

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- ✓ A random audit of agency files to ensure adherence to current procedures
- ✓ A comprehensive report to management detailing the results of the audit and making recommendations for areas of improvement

If there have been no serious past E&O issues, some carriers will allow a credit of up to 10% on the agency's E&O policy for conducting such an audit.

Development of an E&O loss prevention program, as outlined above, will demonstrate to your E&O carrier that you are serious about reducing or eliminating E&O situations.

How to Develop a Procedures Manual

Creating a procedures manual from scratch can be a daunting task. However, nearly every E&O attorney will tell you that it is a necessary step in reducing or eliminating E&O losses. Of course, once it is prepared, it must be used by everyone in the agency. You may have to “sell” your staff on the benefits of having a procedures manual, which includes E&O loss control, but also results in greater efficiency and productivity for the staff, freeing up time to do what the employee prefers and does best—selling and servicing accounts.

There are a few ways to obtain or create a procedure manual:

- ✓ Hire a consultant to create customized workflows and procedures based on your agency's operations and its management information system
- ✓ Purchase a procedures template for each department of the agency and customize it using agency personnel
- ✓ Develop a customized procedures manual using agency staff

Obviously, the first method, hiring a consultant, is the easiest in terms of not stretching the agency's staff resources too thin. It will still require a team of agency personnel who will work with the consultant to create the customized documents. The process can take anywhere from three days to three months, and the cost will vary based on the amount of time spent by the consultant on-site and off, the number of departments in the agency, and the extent of the project.

Purchasing a template is usually the least expensive method, but it can also require a lot of changes based on the agency's way of doing business. A template that is specific to the agency's choice of management system would be best. Your agency E&O Improvement Specialist can be instrumental in helping you complete the customization that is necessary to make the procedures manual useful.

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The last method, creating the manual using only internal resources, is both time-consuming and expensive, and smaller agencies may not be able to spare people in order to complete the task. Creating the manual tends to be a “round to it” project in most agencies, and one that often gets put on the back burner when people are already feeling overworked. If you decide to use this method, it will still require forming a team who can divide the work among themselves and hold each other accountable to stay on track. You can use the sample procedures included in this manual to get started on this project.

- ✓ Regardless of which method you choose, prepare yourself for an interesting journey. You will probably find, during the course of the project, that you don't really have a single agency—you have as many different ways of doing things as you have people. Some people, especially those who have been doing things a certain way for a very long time, will bristle at the change. Others will welcome it. In the end, everyone will have to give something up in order to gain something better. The result will not only be better E&O loss control, but a more efficient and productive staff, happier customers, and an improved financial picture for the agency.

CASE STUDY—Two Blind Mice

Lizzie moved from out of state and took a CSR position at a large agency. She had been in the insurance business for about one year. The agency had recently hired a new producer, Tom, who was writing a significant amount of new business and needed help. Lizzie was assigned to work with Tom. Tom's book of business consisted of varied sizes and types of accounts. The CSR who had worked with him from the beginning had left the agency and Lizzie and Tom were working long hours to try to keep the work caught up.

Shortly after starting her new job, Lizzie received a phone call from one of the agency's customers, a local law firm. They were inquiring why their renewal premium had nearly doubled from the previous year. Lizzie told them she would check with Tom and let them know. Tom advised Lizzie that the renewing carrier was no longer competitive for this class of business, and told her to get a quote from another company. To everyone's surprise, and the customer's delight, she was able to get a quote with another carrier for about the same as they had paid the prior year.

When she sent the quote to the customer, Lizzie's letter indicated that "the coverage was nearly identical" to the expiring policy and that there were only one or two differences. She did not indicate what they were. Since she was changing carriers, she also sent out applications to the customer to have them complete and update them, based on the agency's files.

The new policy was received and following a review by both Lizzie and Tom, the policy was mailed to the customer. In his cover letter, Tom advised the customer that since he was frequently out of the office, they should contact Lizzie for anything they needed as she was "very familiar" with their account.

Two weeks following the receipt of their new policy, the customer called to advise that one of their employees, using his own vehicle on company business, had struck a pedestrian. The claim was turned in to the insurance company, but was quickly denied due to the fact that non-owned auto coverage was not provided.

What went wrong?

CASE STUDY—Two Blind Mice

What are the major issues in this case?

What were the root causes of the loss?

What could have been done differently by the agency? By the producer? By the CSR?

CASE STUDY—Get a Life

The Jones Agency prides itself on being a full-service agency, and even states in its brochures and form letters that they provide “any and all types of insurance.”

Doug Jones, the agency’s owner, has enjoyed many years of sales success and has excellent relationships with most of his customers, who are typically the owners of large businesses. In fact, Doug sees many of his customers socially and serves on various community boards with some of his larger customers.

The agency has done a good job of rounding out accounts, typically writing property, liability, workers’ compensation, automobile, professional liability and other lines of business. In fact, the agency uses a checklist approach when preparing new business and renewal proposals to ensure that recommended coverages are discussed with each customer and any rejections noted on the proposal.

Doug was upset to learn that one of his longtime customers had passed away unexpectedly from a heart attack. Since Doug had a personal relationship with the customer and his wife, he made a personal visit to the widow upon learning of his friend’s passing. Although she was clearly suffering from the grief of her sudden loss, the customer’s widow seemed secure in the knowledge that she would at least be well taken care of financially because she was certain Doug had arranged life insurance for her husband.

Although Doug had appointments with a couple of life insurance companies, he had sold very few policies through the years, usually when one was required in some kind of business buy-sell arrangement or when one of his customers was going through a divorce. The topic had never been brought up with his recently deceased customer, whose widow is now suing Doug for failing to provide life insurance for her husband.

What went wrong?

CASE STUDY—Get a Life

What are the major issues in this case?

What were the root causes of the loss?

What could have been done differently by the agency? By the producer? By the CSR?

What do you think was the outcome?

CASE STUDY—What's In a Name?

The TLC Agency specializes in providing insurance coverage for owners and operators of senior living centers, including nursing homes, assisted living facilities, and cooperative apartments. All lines of property and casualty coverage were provided for most customers, including Professional Liability.

One of the agency's customers called to add a new location to their package policy. The producer took the call and inquired whether or not Professional Liability should be included for this location. The insured said it was not required as the new location was managed by them only indirectly. The producer made a hand-written note that the insured did not want Professional Liability coverage, and placed the note in the insured's paper file.

The location was added to the insured's package policy for property and liability coverage and an endorsement and invoice were sent by the CSR when they were received from the insurer.

Several years later, and following the deaths of two patients at the "new" facility, the customer was sued for negligence. When they notified the agency of the suit, they were advised to send the lawsuit to the agency for submission to the insurer. The agency turned the claim in to both the General Liability and the Professional Liability carrier who insured the customer's other locations.

The claim was denied by the General Liability carrier because the nature of the claim was not within the insuring agreement of the General Liability policy. The claim was denied by the Professional Liability insurer because the entity operating that location was not listed as a Named Insured on the policy.

What went wrong?

CASE STUDY—What's In a Name?

What are the major issues in this case?

What were the root causes of the loss?

What could have been done differently by the agency? By the producer? By the CSR?

What do you think was the outcome?

CASE STUDY—Don't Take it Personally

Donna was employed as a CSR for a large, well run agency in a major U.S. city. Unfortunately, she was having some very serious personal problems that required her to be absent from work on a fairly regular basis.

About 90 days prior to the renewal of one of the agency's largest accounts, the underwriter called Donna to inform her that one of the insured's buildings was too old to qualify for coverage and would have to be replaced upon renewal. The underwriter followed up with a confirming letter.

A week or so after the renewal policy had been delivered by the producer (also an agency owner), the agency's operations manager was watching the news and realized that the major fire being covered on television was one of the locations of their large customer. The building was fully engulfed and looked to be a total loss. She immediately drove to the office, pulled up the electronic file, and called the company's 800 number to report the loss.

The person taking the claim report advised her that the location was not on the schedule attached to the policy. Not believing what she was hearing, she asked them to double check. The claims clerk read to her the notes in the file and confirming letter that had been sent to Donna. The building had been deleted from the schedule at renewal.

The operations manager conducted an audit of Donna's desk and discovered a locked file drawer that contained the letter from the carrier, along with several months of other unprocessed work. Coverage for the destroyed building had not been replaced and since Donna had not updated the system, the electronic file still showed the location on the property schedule.

What went wrong?

CASE STUDY—Don't Take it Personally

What are the major issues in this case?

What were the root causes of the loss?

What could have been done differently by the agency? By the producer? By the CSR?

What do you think was the outcome?

CASE STUDY—Where the Son Rises

Betty Hernandez had been a customer of the Resnick Agency for many, many years. During that time, she had purchased a large number of single-family dwellings that she rented to others. All of the policies had been written on a direct bill basis with the insurance company.

As she got on in years, Betty's properties were managed by her son, Tom. When Betty's health began to deteriorate, Tom found it necessary to place her in a long-term care facility. Since he held Betty's power of attorney, he informed Resnick that the mailing address on all her rental dwelling policies should be changed to his address. The agency forwarded change notices to the companies and the policies were endorsed.

Less than a year later, Tom moved out of the state, but was still managing Betty's properties. He once again informed the agency to change the mailing address on Betty's policies. One of the carriers refused to make the change, stating that it was against their policy to have an out-of-state mailing address on a policy covering property within the state. The CSR at the Resnick Agency told Tom about the problem with that carrier, but also told him she had a solution. She changed the mailing address on that policy to Resnick's and advised Tom that whenever she received any documents from the carrier pertaining to that policy, she would immediately forward them on to him at his new home. She kept her word for two years following Tom's move, forwarding billing notices, correspondence, and late notices from the insurer.

During the third policy term following Tom's move out of state, the agency received a notice of cancellation. A new CSR was handling the account and did not forward the notice to Tom.

Some months later, the agency received a call from Tom to report that there had been a fire and one of Betty's rental dwellings had been destroyed. The claim was denied by the carrier because the coverage had cancelled for non-payment. Tom felt he owed it to his mother to pursue an action against the Resnick agency.

What went wrong?

CASE STUDY—Where the Son Rises

What are the major issues in this case?

What were the root causes of the loss?

What could have been done differently by the agency? By the producer? By the CSR?

What do you think was the outcome?

CASE STUDY—The Good Samaritan

Osgood Builders was a large residential contractor. They had purchased their liability insurance through the Towers agency for many years, and although they were an excellent account for the agency in many respects, they also had developed an adverse loss ratio over the last few years.

Mark, the producer on the account, had found it increasingly difficult to place coverage for Osgood due to their loss experience, their size, and the nature of the work they performed. At renewal, Mark knew he was going to have a problem placing coverage on terms Osgood would accept. He notified the insured of this potential problem, and suggested they pursue other alternatives.

Two weeks prior to the renewal date, Mark had received a call from the insured with good news—Osgood had identified a possible market, mentioned to them by another contractor. Mark immediately made a submission, and to his delight, got a quote.

At Tower's weekly sales meeting, Mark reported on Osgood's renewal. Nick Towers, the agency's owner, asked Mark what the A. M. Best rating was for the newly discovered carrier. Mark advised that it was C+. Nick informed Mark that he could not offer that quote to Osgood, since agency procedures (and the agency's E&O policy) did not permit use of a carrier with a rating lower than B-. Mark was disappointed, but informed Osgood he would not be able to help them with the renewal policy and that they would have to use another broker.

Osgood placed the coverage through the broker, but was informed that they did not have the ability to issue certificates of insurance. Osgood's CFO called Mark and asked, based on their long-standing relationship, if Mark's office could issue the certificates on their behalf. Osgood offered to pay for this service and Mark did not feel this was a breach of the agency's procedures.

Towers issued some 4,000 certificates and collected a sizeable fee from Osgood. At the direction of several of the certificate holders, the "endeavor to" wording had been crossed out on the certificate.

The coverage arranged by Osgood through the other broker turned out too good to be true. Approximately 60 days after the renewal, the insurance company was taken into receivership, and ultimately liquidated. Osgood was sued by several of the certificate holders when claims that should have been covered by its policy were left unpaid following the bankruptcy. Many of the claims involved serious injuries. Towers was enjoined in those lawsuits by the certificate holders, who alleged fraud and misrepresentation.

What went wrong?

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CASE STUDY—The Good Samaritan

What are the major issues in this case?

What were the root causes of the loss?

What could have been done differently by the agency? By the producer? By the CSR?

What do you think was the outcome?

CASE STUDY—No Problem or Big Problem

Simonson Paint Company was a customer of the Merriweather Agency for over 25 years. In fact, Jacob Simonson's and Frank Merriweather's sons, who were now running their respective businesses, attended high school together.

Simonson Paint owned several retail stores, but also functioned as a manufacturer of specialty paints. Market conditions over the past several years, despite a very good loss ratio, forced Merriweather to place the Simonson general liability coverage through an excess and surplus lines broker, since the agency had no standard markets available for what was considered the high-hazard exposure of paint manufacturing.

When the new policy was received in the agency, it was reviewed by Melinda Sanchez, the CSR. She noted that the policy contained an exclusion for "residential construction" that was not on the previous policy. Melinda made a call to the surplus lines broker to discuss the exclusion. She was told that the intent of the exclusion was to preclude any kind of construction defect claim and that there was "no problem" with the exclusion for this insured since they did not have any contracting exposures.

Melinda gave the new policy to Josh Merriweather for delivery to the insured. Josh also noted the exclusion, but since he knew Simonson did not do any residential work, he was not concerned and did not point out the exclusion to Ben Simonson.

A contractor purchased some paint at one of the Simonson retail stores. This particular paint was manufactured by Simonson. While being used to paint a home in very warm weather, the paint combusted, resulting in a total loss to the newly built house. The Homeowner's insurer paid the loss, and proceeded to subrogate against Simonson's general liability policy. The claim was denied by the insurance company because the damage had been caused to a residential structure.

What went wrong?

CASE STUDY—No Problem or Big Problem

What are the major issues in this case?

What were the root causes of the loss?

What could have been done differently by the agency? By the producer? By the CSR?

What do you think was the outcome?

CASE STUDY—Dig A Little Deeper

Penny was contacted by another agent who was acting as an insurance consultant for a jewelry store and was seeking quotes through several agencies. The insurance consultant provided a list of insurance coverages and limits, including business interruption. Penny put together quotes based on the coverages and limits information supplied by the insurance consultant and the jewelry store decided to place its insurance through Penny.

Penny dealt directly with employees of the jewelry store while preparing applications and in obtaining supplemental information requested by the insurers as part of the application process. However, she did not attempt to determine whether all of the jewelry store's risks had been addressed by the coverages requested by the insurance consultant, or whether the limits requested by the consultant were adequate.

Several months after the various policies were issued, the jewelry store was destroyed in a catastrophe. The property and contents were fully addressed, workers compensation addressed employees injured or killed, but a dispute arose regarding the limits of the business interruption coverage. The jewelry store asserted that its business interruption losses exceeded its business interruption limits by several million dollars and that, as a result, the insurer had asserted a co-insurance penalty. The jewelry store filed suit against the insurer, the insurance consultant, and Penny.

What went wrong?

CASE STUDY—Dig A Little Deeper

What are the major issues in the case?

What were the root causes of the loss?

What could have been done differently by the producer?

What do you think was the outcome?

CASE STUDY—Going the Extra Mile

Anne was an experienced agent at a small agency. A new client came to the agency. Anne met with him to discuss his insurance needs. The client owned a large home in an area that was prone to flooding. Anne recommended and placed Homeowners coverage for the client with appropriate limits of one million dollars for the structure and contents limits in the amount of \$500,000.

Because of the home's location in an area prone to flooding, Anne also recommended flood coverage to her client. The client agreed with her recommendation and Anne placed flood coverage for the client through the NFIP. The limits on the flood policy were \$250,000 for the structure and \$100,000 for the contents.

A huge rain event struck the area and caused widespread flooding. The client's home ended up with three feet of water in it causing extensive damage to the structure and to the contents of the home. The loss was adjusted and it was ascertained that the structure sustained \$400,000 of damage. In addition there was \$200,000 of damage to the home's contents. There was no coverage under the Homeowners policy as the damage was caused by flooding which was excluded. The NFIP paid its limits. The client was left with a \$250,000 total shortfall in coverage. The client then sued Anne and her agency.

What went wrong?

CASE STUDY—Going the Extra Mile

What are the major issues in this case?

What could have been done differently by the agency?

What do you think was the outcome?

CASE STUDY—Cover your Bases

Clark Carlson left Big Time Accounting, to open his own business Clark Carlson, CPA. Clark met with his independent insurance agent, Anne Albright to discuss what coverage he would need for his new venture. Anne and Clark settled on a BOP and filled out the requisite applications.

Noting Clark was a CPA, Anne suggested he would need professional liability coverage. She then asked if he or any of his employees had any other professional designations. Clark admitted that he was also a licensed attorney. Anne asked Clark to explain what services Clark Carlson, CPA would be providing its customers. Clark opined that while the majority of his practice would be accounting, he would also file annual corporate reports and create new business entities for his clients as needed.

Anne submitted applications for professional liability coverage, noting that Clark was both a CPA and attorney. She also included a description of the services Clark Carlson, CPA would be performing, as provided by Clark. She requested quotes to cover these services.

Every quote Anne received included separate coverage for Clark as a CPA and as an attorney. Clark accepted a quote for professional liability coverage as a CPA, but declined to purchase professional liability coverage as an attorney.

What went wrong?

CASE STUDY—Cover Your Bases

What did the Anne do right in this case?

Now that Clark has declined the attorney professional liability coverage, what should Anne do to protect herself and her agency?

When should an agent ask a customer about professional designations and offer professional liability coverage?

CASE STUDY—Communication is Key

Olivia, a CSR for Joust Insurance Agency, has been placing coverage for P&G Construction for a number of years with Heritage Insurance.

Joust has a membership with Ambest.com and receives regular updates on the rating of its carriers. Joust's producers are trained to review the information and to note in their client files any negative ratings issues. While Joust will not specifically recommend moving a policyholder to a different carrier, it will recommend consideration of the same to a client if a carrier's rating falls below B+. Of note, Joust's E&O policy excludes coverage for claims arising out of a carrier's insolvency if the carrier is rated below B+. As such, Joust will have the client sign a waiver of any claims against the agency due to insolvency if it decides to continue coverage with the low rated carrier.

Olivia recently got married and was out of the office for just over two weeks. She returned to a desk full of work about a month ago, August 13, 2006. In her inbox was a July 1, 2006 AM Best weekly newsletter advising of Heritage's downgrade from B+ with an outlook of "stable" to B with an outlook of "negative." Olivia noted the same in P&G's file in order to discuss the same with P&G at its upcoming renewal.

P&G's CGL policy expired January 15, 2007. In mid-November Olivia met with the principle of P&G to discuss the renewal. She advised P&G of the rating issue and brought along several quotes from better rated carriers. The quotes were much higher than Heritage's quote. In order to save money, P&G decided to renew with Heritage. In accordance with Joust's guidelines, Olivia obtained a signed waiver of claim from P&G.

Heritage was placed in receivership on March 15, 2007. On April 3, 2007, P&G Construction reported a claim to Olivia at Joust. At that time Olivia first discovered Heritage had been placed in receivership. Olivia assisted P&G with submission of the claim to the trustee, but it appears that P&G will receive much less than the full value of the indemnity it would have recovered if Heritage had not gone into receivership. The claimant has indicated it intends to seek any uncovered amounts from P&G's assets.

What went wrong?

CASE STUDY—Communication is Key

What are the major issues in the case?

What could have been done differently by the agency? By the CSR?

What do you think was the outcome?

CASE STUDY—All or Nothing

John was an experienced agent at a medium sized agency. John placed CGL, Commercial Auto and Work Comp for his longtime client Hannah. John also sold Hannah her homeowners policy. In addition to her business interests, Hannah owned a very large house valued at \$950,000 on which there was no mortgage. Hannah paid her insurance premiums directly.

Hannah had an extensive history of neglecting to pay her premiums on both her business and her homeowners policies. Over the years, when Hannah missed premium payments on her business coverages, her agent John would routinely call Hannah and /or write to her and remind her to pay her premium. On certain occasions, the agent even paid the premium on Hannah's behalf. With respect to her homeowners coverage, Hannah had received 9 notices of cancellation for non-payment of premium in a six year period. On 5 of those 9 occasions, John called Hannah and reminded her to pay her premium.

The agency had an internal procedure in the event that one of its clients received a notice of cancellation. It was the agency's policy to call the carrier any time a notice of cancellation was received to confirm whether the account had been paid. Then the agency would follow-up either with a letter or a phone call to the insured if the payment was still outstanding.

In this case, Hannah failed to pay her homeowners premium yet again. The carrier properly sent out its notice of cancellation to both the agency and Hannah. The agency did not contact Hannah upon its receipt of the notice of cancellation and the policy was ultimately cancelled. Four months following the cancellation, the home and all of its contents were completely destroyed by fire. Because there was no mortgage on the property, no forced placed coverage had been obtained by a mortgage company. Hannah submitted a claim and proof of loss to the carrier. The carrier denied coverage for the loss based on the cancellation. Hannah then sued both the carrier and John and his agency.

What went wrong?

CASE STUDY—All or Nothing

What are the major issues in this case?

What could have been done differently by the agency?

What do you think was the outcome?

CASE STUDY—Clear Communication

George was an experienced agent at a small agency. He had a small manufacturing client for whom he had placed a number of coverages, including CGL, equipment, and workers' compensation. At a routine meeting, the client told George that it had decided to move its plant operation to a different location. The new location was in the same metro area, but would be in a different state. The time frame for the move was uncertain, but would likely be within the next six months or so.

George told the client to let him know when the move was closer, so that he could advise the equipment insurer of the change in locations, and could apply for workers' compensation coverage in the other state. He followed up with the client by letter in which he told the client that it would be important for him to know when the client had moved.

Several months later, George called the client and discovered that the client had just completed its move and was resuming plant operations in the new location in the other state. George immediately reported the change in equipment location to the equipment insurer. He also sent application forms to the client for workers' compensation coverage in the new state to which it had moved operations.

George had to follow up with the client several times by phone before the client returned the completed workers' compensation applications to him after several weeks. The client asked whether it should cancel its existing workers' compensation policy since it was no longer in that state. George told the client to leave the policy in effect, thinking to himself that it would be better to have a workers' compensation policy in the wrong state than to have no workers' compensation policy at all.

George was extremely busy, as was his CSR, and there was a few days delay in getting the applications submitted to several workers' compensation insurers. George did not apply for workers' compensation coverage through the State Fund, in part because the client had to first be turned down by several insurers in the private markets and in part because he thought he could obtain the policy through the market at a lower price.

The insurers were not all prompt in responding to the applications, and some requested additional information that George in turn had to get from his client. However, a month after the phone call in which he learned his client had moved its operations to a new state, George obtained a quote for workers' compensation coverage, and the premium was quite reasonable.

George called his client as soon as he received the quote to get the client's approval to go ahead with the new workers' compensation policy. George left a voice-mail telling the client that he needed to discuss the insurance situation. George expected the client would call back

quickly and did not set a reminder on his calendar to follow up. A week later, his client did call, but it was to report that one of his employees had been severely injured at the plant in the new state. The existing workers' compensation insurer denied coverage for the claim because it took place in a different state at the new plant location. The client sued George alleging that George had been negligent in failing to obtain workers' compensation coverage that would apply to its new location.

What went wrong?

CASE STUDY—Clear Communication

What are the major issues in the case?

What could have been done differently by the producer?

What do you think was the outcome?

CASE STUDY—He Said She Said

Midtown Emergency Medical Transport has been placing its CGL coverage through Teresa's agency for ten years. Teresa and Frank, MEMT's owner, have a friendship predating their business relationship. Frank has gone to Teresa for all personal and commercial insurance needs during this ten-year period. Frank asked Teresa to market the expiring CGL claims-made policy for any available premium savings.

Teresa was able to secure a lower quote for another claims-made policy. Both policies included the heading "This is a Claims-Made Policy," and each had reporting and notice provisions that made report of any matter during the policy period a condition precedent to coverage.

During the application process, Teresa met with Frank via teleconference and took him through the application for the new carrier. The new carrier's application advised that it would rely on the applications for other carriers for the past five years. The application inquired whether MEMT was aware of any claims, suits or matters that could give rise to a claim. Frank advised Teresa that he was not aware of any such claims. Nonetheless, Teresa didn't mark any response to the question, and forwarded the application to Frank for his signature. This is the only documentation of Teresa and Frank's discussion of the issue.

Teresa, in reliance on Frank's representation that there were no claims, suits or incidents that could give rise to a claim did not recommend any extended reporting tail coverage for the expiring policy.

The old policy expired and the new policy went into effect on January 1, 2005. Teresa forwarded a copy of the new policy to Frank along with a cover letter that stated: "Thank you for placing your insurance with our business. As we discussed, this policy replaces your prior one with no significant difference in the available coverage. Please review this policy and contact me with any questions you may have. You are responsible to review and understand your policy of insurance."

On June 3, 2005, Frank submitted a claim to his new carrier for a suit filed against his company on May 15, 2005. Upon investigation, the carrier discovered that the plaintiff's attorney had sent a letter to MEMT on September 12, 2004 in which the attorney described the incident that allegedly caused the plaintiff's injuries and demanded \$150,000 for those injuries. MEMT had never sent this letter to Teresa's agency nor to the prior carrier directly. MEMT's two prior claims during its ten year business relationship with Teresa's agency were handled with the first being reported to Teresa's agency, and the second being sent directly to the carrier by MEMT's general counsel.

A Practical Guide to Agency E&O Risk Management

Frank's current carrier denied coverage because based on the policy's definition of "claim," the claim had actually been made on September 12, 2004. Frank's previous carrier denied coverage based on the fact that the matter had not been reported during the policy period and no reporting tail was in effect.

MEMT incurred approximately \$100,000 in defense costs and ultimately settled the suit for about \$250,000. MEMT is now suing Teresa's agency. Frank now claims that he discussed the September 2004 letter with Teresa during the application process.

What went wrong?

CASE STUDY—He Said She Said

What are the major issues in the case?

What were the root causes of the loss?

What could have been done differently by the CSR?

What do you think was the outcome?

CASE STUDY—A Fresh Set of Eyes

Barry Businessman entered ABC Insurance looking to change both his agent and carrier. Barry's business had recently suffered a small fire loss. That was when Barry learned his policy contained a 100% coinsurance clause and the business was underinsured. Accordingly, the carrier did not fully compensate Barry for the loss. Barry was not pleased with his agent or carrier with the way his coverage had been placed or with how his loss had been adjusted. Allen Agent, owner of Allen's Independent Insurance Agency asked Barry for copies of his current coverage and he assured Barry that he would receive excellent service and coverage through his agency.

Allen filled out applications for replacement coverage based on the information contained in Barry's current policy. The only difference was Allen increased the amount of property coverage and requested a 90% coinsurance clause as opposed to 100%. After he shopped the coverage he scheduled a meeting with Barry to review his options. Barry purchased the coverage Allen suggested and Allen landed a major account for his agency.

Six months later, heavy rain caused a flood to swamp Barry's business. Barry called Allen to report the claim. Allen informed Barry that he did not have flood coverage on his business. Allen did not suggest flood coverage, because Barry did not have it when he came to the agency.

What went wrong?

CASE STUDY—A Fresh Set of Eyes

What were the root causes of the loss?

What could have been done differently by the producer?

What do you think was the outcome?

CASE STUDY—In Over Your Head

Andrew was an experienced agent at a large insurance agency. Andrew placed Commercial Property coverage for his client who was a real estate developer. Among the properties he owned, the real estate developer owned a shopping center.

The agent and the property developer had verbal discussions when the policy was initially placed regarding the value of the property. According to the agent, the value of the building was ultimately determined by the real estate developer, but nothing was put in writing by the agent to reflect how the value was determined or whether the client agreed with the valuation. The agent procured a replacement cost property policy with \$2.5 Million in replacement cost for the building.

The policy was then renewed each year for 5 years. During this time period, neither the agent nor the client re-visited the issue of the valuation of the property or considered or discussed possible increases in the value of the property.

The shopping center then burned to the ground. When the client submitted the claim, the carrier paid the limit of the policy. However, the property owner claimed that the replacement cost of the property was actually \$7MM and claimed that the property was undervalued. The real estate developer admitted receiving the renewals each year but not reading them. He further claimed that he completely relied on his agent to determine the appropriate insurance coverages, that it was the agent that set the initial value of the property and that the agent never recommended an appraisal at any point. The real estate developer proceeded to file suit against Andrew and his agency.

What went wrong?

CASE STUDY—In Over Your Head

What are the major issues in the case?

What could have been done differently by the agency?

What do you think was the outcome?

CASE STUDY—Document, Document, Document!

Dan was contacted by his wife's uncle who was purchasing a business and wanted Dan to handle getting insurance coverages for him. The main activity of the business involved installation, repair, and testing of petroleum storage equipment, including underground tanks. Dan obtained several policies for the business, including commercial auto, workers compensation, property insurance, and a CGL.

Dan did not have other clients involved in this type of business and was unable obtain a CGL that did not exclude pollution claims. Dan went through the coverages with his client and told him that he had not been able to obtain pollution coverage. He recommended to his client that the client try to get pollution coverage elsewhere. Dan suggested pollution coverage might be available through the client's professional association. Dan later followed up with the client in person and the client told him he'd looked elsewhere but had decided not to buy pollution coverage because it was too expensive. At renewals, Dan reminded his client that he did not have pollution coverage.

Three years later, a lawsuit was filed against the client alleged that an underground storage tank it had installed for a gas station had leaked. The CGL insurer undertook to defend the lawsuit under a reservation of rights but took the position that any damages arising out of petroleum that leaked from the tank were not covered and would not be paid by the insurer. The client filed suit against Dan. The client denied that Dan had told him that he had not been able to obtain pollution coverage and denied that he had chosen not to obtain coverage elsewhere due to cost.

What went wrong?

CASE STUDY—Document, Document, Document!

What are the major issues in the case?

What could have been done differently by the producer?

What do you think was the outcome?

CASE STUDY—System Failure

Fred, a CSR with the TNT Agency, placed a minimum-limit personal auto policy for Oliver. The policy had effective dates of 11/1/04 – 5/1/05. The carrier billed Oliver directly and had no practice of copying TNT on any correspondence sent directly to any insured – invoices, cancellation notices or renewal notices. None of this information, on any policyholder account, was ever copied to TNT.

Fred left TNT in late April of 2005. TNT's file contains a copy of the renewal notice that the carrier sent to Oliver on April 15, 2005. On October 27, 2005, Oliver called TNT and was helped by Bob. Oliver reported that he had purchased a new car on October 25, 2005 and wanted it added to his personal auto policy.

The carrier has an agency-facing computer system. Bob entered the online system and added Oliver's newly purchased used vehicle to the policy. He did not confirm that the 5/1/05 – 11/1/05 policy was in effect for Oliver, but assumed it was since the system allowed the endorsement to be added. Bob then mailed Oliver a temporary insurance card with no other correspondence enclosed.

Unknown to TNT, the carrier had cancelled the 5/1/05 – 11/1/05 policy for nonpayment effective June 21, 2005. A refund had been issued to Oliver, but TNT had not received any copy or notice of the cancellation or the refund. There had been no policy in effect at the time Bob logged onto the carrier's system and, he believed, added the newly purchased car to the coverage.

TNT received a Department of Insurance complaint on July 12, 2006 that had been filed by Oliver. Oliver had been in a car accident on February 20, 2006 and was sued for damages by the other driver. The accident involved the newly purchased car that Bob had, he thought, added to an effective policy via endorsement. The carrier denied on the basis that Oliver had not had a policy of insurance in effect since June 21, 2005. Oliver alleges that, although he had paid no premiums to the carrier for the addition of the new car, he reasonably believed he was covered in the vehicle at issue based on TNT's issuance of a temporary insurance card.

What Went Wrong?

CASE STUDY—System Failure

What are the major issues in the case?

What are the root causes of the loss?

What could have been done differently by the agency? By the producer?

What do you think was the outcome?

Answers to the Case Studies

Introduction

The outcomes of the various cases included in the Student Manual are included here for your use in presenting the seminar. Each case is followed by a series of questions:

1. What are the major issues in this case?
2. What were the root causes of the loss?
3. What could have been done differently by the agency? By the producer? By the CSR?
4. What do you think was the outcome?

The first three questions have no right or wrong answers. You should become very familiar with each case, in order to lead a discussion with the audience. Depending on the audience, you may wish to focus on a particular job function, such as producer or CSR.

The last question...the outcome...is provided for you in this document. Some of the participants may want to argue the outcome, but don't let the discussion go on very long. After all, these are all actual cases and the outcome is the outcome.

CASE STUDY—Two Blind Mice

What are the major issues in this case?

This case is an example of two fairly new agency employees who were teamed up to handle the producer's accounts. The previous CSR had many years of experience and had worked with the producer's accounts long enough to understand them, but when she left, it took a while for the agency to find a replacement. Lizzie started at the agency with a backlog on her desk, and she and the producer were working diligently to get the work caught up. In the meantime, there was little time for Lizzie to be fully trained as a CSR.

What were the root causes of the loss?

When the customer called to inquire about their renewal premium, which was much higher than the previous year, Lizzie was correct in seeking the producer's input. Although she was able to get a quote at a lower price from another carrier, she did not spend the necessary time comparing the coverage provided by each company.

What could have been done differently by the agency? By the producer? By the CSR?

If Lizzie had taken the time to compare coverage, she likely would have noticed that the new policy did not include non-owned auto coverage—crucial for a law firm with employees running errands using their own automobiles. The coverage was available from the new carrier, but for an additional premium.

What do you think was the outcome?

The letters from Lizzie and Tom were ultimately used to demonstrate that the customer had been misled about the new quote ("the coverage is nearly identical") and Lizzie's qualifications ("she is very familiar with your account"). Lizzie's defense was that the customer should have compared the coverage and discovered the difference—the court did not agree.

The underlying injury to the pedestrian, luckily, was not as serious as it could have been, however the person did require plastic surgery and ongoing physical therapy. The law firm was facing a \$1,000,000 lawsuit, without benefit of insurance coverage. They sued the agency for their loss.

The agency's E&O carrier paid \$950,000 on behalf of the agency. The agency was responsible to pay its \$50,000 deductible to the law firm. They remain a customer of the agency.

CASE STUDY—Get a Life

What are the major issues in this case?

The agency's brochure definitely overstated the services and products they could offer. In addition, it was determined that Doug had a "special relationship" with his customers, because he had handled their insurance for so long and he knew intimate details of everyone's life because of his personal relationship with them.

What were the root causes of the loss?

Doug's efforts at cross-selling were ultimately used against him in this case. He was licensed to sell life insurance and had company appointments, so he could have provided coverage to his customer, but he had never recommended it. It was determined that his special knowledge of his customer's personal situation should have made a recommendation of life insurance coverage a "no brainer". The checklist he had used even listed life insurance.

What could have been done differently by the agency? By the producer? By the CSR?

Depending on the standard of care in a particular state agents may or may not be typically held responsible for recommending every type of coverage to every customer, some exposures are considered so obvious that failing to offer the coverage can result in an E&O loss. Doug could have offered the coverage or forwarded his client to another source to get the coverage. Any coverages that are declined by the clients should be documented in writing with the client initialing them.

What do you think was the outcome?

The agency was able to settle this case before entering into a protracted legal battle with the customer's widow. Doug felt terrible that she was left in a bad financial position, but the thought of selling her husband life insurance had honestly never entered his mind. The widow was awarded damages of \$1,500,000. Doug's E&O carrier paid \$1,000,000 (less Doug's deductible of \$10,000). Doug felt so responsible for this situation, that he happily paid the balance of the loss out of his own pocket.

CASE STUDY—What's In a Name?

What are the major issues in this case?

This case is a good example of not asking enough questions and truly assessing the loss exposures of the customer. The producer (who really shouldn't have been taking this kind of a service call from a customer in the first place), asked the customer whether or not professional liability coverage was needed, rather than asking sufficient questions to help the customer determine whether or not it was necessary.

What were the root causes of the loss?

Joint ventures, as legal entities, are not automatically covered by a standard liability policy. The carriers' denial of these claims was proper and in keeping with the letter of the contracts. The producer did not do a thorough job of risk assessment.

What could have been done differently by the agency? By the producer? By the CSR?

The customer had indicated that the management of the new location was "handled indirectly". The natural follow-up question should have been to determine exactly how this location was being managed. If he had asked the question, he would have found out that his customer had entered into a joint venture arrangement with a management firm for the operation of the nursing home.

What do you think was the outcome?

The customer did not sue the agency or the producer in this case. The joint venture arrangement did not become known to the agency until the claim happened and the customer felt it was their responsibility to have brought this to the producer's attention. The nursing home was able to successfully defend itself from the wrongful death action brought by the patients' families, so there was no underlying cause of action for which to bring a suit against the agency. In a sense, the agency and the producer "dodged a bullet".

CASE STUDY—Don't Take it Personally

What are the major issues in this case?

This case is instructive on many levels. It is a “perfect storm” of various issues that conspired to cause the loss to the agency.

The CSR was having serious personal problems and everyone in the agency knew it—including the other CSRs. When asked, following the loss, if they knew if Donna was behind, they all said they did. The owner's next question was why no one had alerted management. The CSRs consistently said that they thought it would be “tattling” and since Donna already had problems, they didn't want to add to them.

What were the root causes of the loss?

The operations manager admitted that had she done a desk audit of each CSR's desk, the locked drawer and the backlog of work would have been obvious. She also said that she thought if the agency's culture had been more open, Donna would have come to her to let her know how behind she was and the work could have been reassigned.

What could have been done differently by the agency? By the producer? By the CSR?

A further complication in this case was the automated file, which had not been updated. When the producer delivered the policies to the insured, he went over the coverage using a Summary of Coverage produced from the agency's management system, rather than the policies themselves. If he had looked at the policies with the insured, they would certainly have noticed that the building was not on the schedule.

What do you think was the outcome?

The building was a total loss. The agency's E&O limit was \$5,000,000. Because the agency was financially stable, they were able to take out a loan to help rebuild the customer's building...nearly \$29,000,000! The customer remains a customer of the agency. (P.S. The CSR was let go the Monday following the fire. She later sued the agency for wrongful termination.)

CASE STUDY—Where the Son Rises

What are the major issues in this case?

The CSR in this case was trying to do the right thing by serving her customer. Unfortunately, she did not anticipate that eventually she would leave the agency, or be assigned to handle different accounts.

What were the root causes of the loss?

For whatever reason, Betty's file was not properly documented so that anyone looking at the file would know the importance of forwarding any important documents to Tom.

What could have been done differently by the agency? By the producer? By the CSR?

As an alternative, the CSR could have placed coverage for this dwelling with another carrier when she found out that the company was not willing to endorse the address change. The practice of circumventing the policies and procedures of the carrier in a direct bill situation should be avoided by all agencies. This loss was the result of trying to be helpful and provide great service, but actually represents a departure from the agency's standard operating procedures.

What do you think was the outcome?

Since the agency had a very high deductible, and the value of the destroyed building was relatively low, the agency decided to pay the loss itself, without involving their E&O carrier. They did, however, advise their E&O carrier of the situation and told them of their business decision. The E&O carrier supported their action. Of course, when renewing their E&O the next year, the agency did have to report that a loss had been incurred.

CASE STUDY—The Good Samaritan

What are the major issues in this case?

Many agencies make mistakes similar to those that caused the problem in this case. In an effort to provide great customer service, some agencies and producers over-promise the services to be rendered. In addition to causing E&O problems, this behavior also results in a loss of profit to the agency, since they do not receive compensation for services provided outside the insurance contract, unless they can legally provide these services for a fee. Although a fee was charged in this case, it was not sufficient to offset the subsequent E&O loss to the agency.

What were the root causes of the loss?

Although a market was available in this case, the A. M. Best rating was inadequate in the opinion of the agency owner and would have left the agency with no coverage in the event of an E&O loss, since the agency's E&O contract required a higher rating.

What could have been done differently by the agency? By the producer? By the CSR?

The obvious course of action for the producer, Mark, was to inform his customer that he could not place the coverage, including the reason for his decision, and leave it at that. Instead, Mark tried to be the Good Samaritan and was "rewarded" with a huge E&O claim.

What do you think was the outcome?

Osgood's liability insurance carrier was determined to be insolvent by the regulator in their state. Several claims were pending at the time of the liquidation, most involving subcontractors. When the claims were unpaid by Osgood's insurer, the subcontractors filed suit against Osgood and the Towers agency. The action against Towers was for fraud in issuing the certificates, since the agency was clearly not the "authorized representative" of the carrier.

The plaintiffs prevailed in their action against the Towers agency. Absent a specific exclusion in their E&O policy, their carrier was required to pay the loss, which was in excess of \$950,000. They were subsequently non-renewed and had a very difficult time placing coverage at renewal. The agency's only E&O quote was from an offshore carrier, with a substantially increased deductible and premium. Nick Towers reluctantly placed the coverage, and immediately amended all of his producer contacts to make the producer responsible to reimburse the agency its deductible in situations such as those that caused this loss. Mark's employment was terminated.

CASE STUDY—No Problem or Big Problem

What are the major issues in this case?

Documentation is the key to preventing or reducing agency E&O exposures. In this case, Melinda's call to the surplus lines broker, and their statement that the exclusion was "no problem" was not documented in the agency's file.

What were the root causes of the loss?

Although it was common knowledge that Simonson also manufactured paint, no one at the agency determined to whom the paint was sold or the type of construction in which it might be used.

What could have been done differently by the agency? By the producer? By the CSR?

Both Melinda and Josh assumed that since Simonson only painted commercial structures, the exclusion would not present a problem. They did not look at the exclusion in light of the paint manufacturing operation. In addition, no one pointed out the residential exclusion to the insured, either in writing or in the meeting when the policies were delivered. Since this was non-standard coverage, every unusual policy provision should have been pointed out to the insured.

What do you think was the outcome?

The agency attempted to cross-complain the surplus lines broker when they were sued by Simonson Paint, but the E&O carrier for the surplus lines broker was able to get a favorable motion for summary judgment granted to them. That left the Merriweather Agency "holding the bag" for this loss.

Since this was a subrogation action by Simonson's customer's Homeowners carrier, it presented an additional challenge. Someone very familiar with how insurance contracts are applied and interpreted might be more likely to pursue an action against an agent if it appears that the agent's actions resulted in the claim's denial. The homeowner was furious that the claim would show up on their loss experience, since it was clear that this was really a products liability claim against Simonson. The owner of the home was also a long-time customer of Simonson, and owned several commercial properties at which Simonson had provided painting services over the years.

Because of the long-standing relationship between the Simonson and Merriweather families, this loss was ultimately settled with each party contributing a portion to reimburse the Homeowners insurer. The agency's portion of the loss was over \$75,000, with an additional contribution of their \$10,000 deductible. About a year after the settlement, Ben Simonson informed Josh Merriweather that he was changing agents.

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CASE STUDY—Dig A Little Deeper

What are the major issues in this case?

The insurance consultant's role was to assess the jewelry store's risks and limits necessary to adequately address the risks, so the consultant is more likely than Penny to be criticized if the limits were not adequate. However, if the client says it relied on Penny to independently assess or confirm that limits were adequate, Penny is put in the position of arguing that was not the scope of her role in the transaction.

What were the root causes of the loss?

If the insurance consultant (and/or the agent) explained in general terms what co-insurance penalty is and that it may apply if inadequate limits are obtained, this may cause the client to make certain it requests adequate limits rather than obtaining lower limits to save costs.

What could have been done differently by the producer?

If Penny put in writing to the insurance consultant and the client that she was relying on the specifications presented to her by the consultant and was not independently assessing the client's needs, this would greatly help her in asserting that position.

If the co-insurance discussion is documented in writing, the client will have a difficult time trying to assert liability against the consultant or agent by claiming to be unfamiliar with co-insurance penalty.

What do you think was the outcome?

The insurance consult paid a large sum in excess of \$500,000, with our agent and the broker paying a lesser sum. While the bulk was paid by the consultant, the agent was still responsible for a significant contribution.

CASE STUDY—Going the Extra Mile

What are the major issues in this case?

- The agent's duty to recognize when excess flood coverage is indicated
- Also note that the agent has a duty to advise client of any applicable waiting periods before flood coverage becomes effective.

What could have been done differently by the agency?

- The agent should have recognized the need for excess flood coverage for this client
- The agent should have documented the offer of excess flood coverage and should the client have declined, the declination should have been documented and the client should have signed off
- Explain to the client that Homeowners coverage does not cover flood loss and document the conversation

What do you think was the outcome?

A finding of negligence by the agent for failing to recommend excess flood coverage.

CASE STUDY—Cover Your Bases

What did Anne do right?

She met with Clark and asked him questions about his new business.

She did not assume that Clark Carlson, CPA would only do accounting work, she asked about other professional designations.

She did not decide whether Clark needed professional liability coverage as an attorney, instead she supplied the information to the carriers and let them make the determination.

Now that Clark has declined the attorney professional liability coverage, what should Anne do to protect herself and her agency?

Have Clark decline the proposal in writing.

Follow up with a letter to Clark, documenting that he has decided not to purchase attorney professional liability coverage and that he may not have professional liability coverage for all services he plans to provide his clients.

When should an agent ask a customer about professional designations and offer professional liability coverage?

When placing professional liability coverage for a customer, ask about other designations and services provided and supply the information to the carriers.

Do not assume you know what professional services will be provided by someone, get it from him in writing.

Do not assume to know what professional liability coverage is needed to cover an individual's/business's services, leave that to the carrier to decide.

CASE STUDY—Communication is Key

What are the major issues in this case?

Joust still faces some exposure if a claim is made despite the waiver. In addition, there was no coverage for this claim with their E&O carrier. Joust should consider whether they should institute a policy of prohibiting the writing of insurance with carrier's rated below B+ in any circumstance.

- What duty does an agent have to a policyholder to communicate potentially negative financial information regarding carriers?
- Communication and documentation of communication to policyholders regarding the financial strength of the carriers where coverage is placed.

What could have been done differently by the agency? By the CSR?

Joust has good processes in place regarding communication of carrier financial stability information. These processes could be refined to ensure that the communication is sent in a timely fashion. Joust should also consider whether the communication should go immediately to policyholders. Olivia/Joust need a system in place to confirm this information is communicated to policyholder clients in a timely fashion rather than simply waiting for the renewal process to begin.

What do you think was the outcome?

P&G's attorney submitted a claim against Joust. Joust, through its counsel sent a copy of the waiver to P&G's attorney, putting him on notice that it had advised of the danger of renewal with Heritage. No further claim was made.

CASE STUDY—ALL OR NOTHING

What are the major issues in this case?

-Agency's duty to notify regarding cancellation: the general rule is that there is no duty to notify the client but if agent then undertakes to notify, a duty is created that didn't otherwise exist and the agent is responsible to fulfill that the duty.

-There is an issue as to whether or not the agent was obligated to follow up with Hannah once the agent received the notice of cancellation. Here Hannah has a stronger case as the agency had a policy of calling and writing to insured and then the agency failed to follow its own procedures.

What could have been done differently by the agency?

-Either follow up on all pending cancellations or have a practice of not doing it at all

What do you think was the outcome?

Liability evaluated at 60% or greater as against the agency and the case was settled for mid six figures.

CASE STUDY—Clear Communication

What were the root causes of the loss?

The follow up letter after the initial meeting could be read to mean that the client should let George know when the move was completed, and not when the client had decided on dates for the move.

George didn't explain his rationale for leaving the existing workers' compensation policy in effect even after the move and so could leave room for the client to believe that it was not urgent to obtain the new policy, or at least to assert that position in subsequent litigation.

Communicating the quote by voice-mail message only, and not by also sending an e-mail, fax, or other form of communication to make certain the client got the message and that the communication would be documented. Making clear that the matter was urgent might also have made a significant difference.

What could have been done differently by the producer?

George should have had the client prepare the applications in advance so they would be ready to submit immediately upon learning of the move dates, if not before.

Setting a reminder date to follow up with the client regarding whether a date for the move had been selected might have given George advance notice of the move.

If George had used a reminder system to follow up on his phone message regarding the workers' compensation quote, the policy would likely have been in place before the worker was injured which would have avoided the e & o claim entirely.

What do you think was the outcome?

The E&O carrier was able to "drop down" and provide workers' compensation benefits. Note that in many states the E&O carrier will be unable to do this as a matter of law. In such cases, open ended liability results against the client subjecting the agent to potentially large exposures possibly in excess of E&O policy limits.

CASE STUDY—He Said She Said

What are the major issues in this case?

There was a gap in coverage created by a failure to give notice of a claim/potential claim or, alternatively, by failure to recommend and procure an extended reporting tail.

- Little to no documentation of what steps were taken during the application process;
- Should an extended reporting period tail be offered on a claims-made policy regardless of the client's representations about claim/potential claim activity?
- What effect does MEMT's prior claim reporting process have on the matter?
- Is Teresa's agency's duty to Frank and MEMT a higher one in light of their past relationship?
- What effect will the unanswered application question regarding knowledge of claims or potential claims have on the suit against Teresa's agency?

What were the root causes of the loss?

- Teresa may not have been fully familiar with the reporting requirements/conditions precedent of the claims-made policy and therefore may not have recognized the risk of a coverage gap.
- Frank failed to disclose the September 2004 demand letter.
- Teresa did not thoroughly document or memorialize the application process she went through with Frank – specifically, Frank's representation that there were no known claims.
- Teresa filled out the application for Frank.
- No extended reporting period tail coverage was offered to MEMT.

What could have been done differently by the CSR?

If an ERP tail had been offered and that offer and rejection memorialized, there would be little to no basis for a claim. Even if Teresa had memorialized, apart from the application, her inquiries into MEMT's knowledge of pending claims or incidents, any claim against Teresa's agency would become much more defensible. Ideally, in order for there to have been coverage available to MEMT, an ERP would have been purchased prior to the first policy's expiration. If she had sent the application to Frank to complete, and then reviewed his responses with him, he would be less likely to convince a jury that he discussed the demand letter with Teresa. Moreover, if she had caught the blank answer, and made sure that it was completed with Frank's answer and contemporaneous signature her testimony would carry more weight.

What do you think was the outcome?

The agent was found liable at trial and assessed damages in excess of \$350,000.

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CASE STUDY—A Fresh Set of Eyes

What was the root cause of the loss?

He relied on the former agent to have suggested and placed the correct coverages for Barry, even though he knew the former agent had not placed enough property coverage for Barry's business.

What could have been done differently by the producer?

He should have worked up the account as if it were new and then checked his findings with the policy currently in place.

He should have compared his proposal against the coverage currently in place with Barry and let Barry decide which coverages to place.

What do you think was the outcome?

The case was settled pre-suit after investigation by the insurance claim department who determined that Allen had undertaken a duty to recommend flood coverage and had negligently discharged his duty. This result was reached despite the fact that Allen operated in an "order taker" state where no independent duty to advise exists.

CASE STUDY—In Over Your Head

What are the major issues in this case?

- Agent's failure to document property valuation process in writing

- Agent's undertaking to set the value of the property when that is potentially outside his/her area of expertise and the agent may not have a duty to undertake this task. In addition, the property owner is in a superior position to know the value of his/her own property

- An insurance broker is not required to ascertain the levels of coverage for a risk. However, if the agent assumed this obligation even though he didn't have to, he thereby created a special relationship that obligated him/her to exercise a greater degree of care and diligence.

- Agent's failure to consider and discuss increases in value of the property over time i.e. by not performing a yearly analysis of coverages and making necessary modifications to the level of coverage.

What could have been done differently by the agency?

- Yearly review of property values with sign off by client
- Written documentation of valuation with client sign-off
- Written recommendation that the client have the property appraised

What do you think was the outcome?

The case was tried and the agent assessed almost \$2MM in damages for undertaking to value the property and not doing it properly as well as failing to review the value

CASE STUDY—Document, Document, Document!

What are the major issues in this case?

You can bet Dan regrets that he told his client verbally that he did not have pollution coverage, but did not follow that up in writing and maintain that writing in his file. That lack of written documentation leaves Dan in a position where his client denies the conversations and Dan has no written documentation to corroborate his testimony.

This claim also demonstrates that even when a client is a family member or friend, you should document important conversations in writing and not assume that the client—even though a family member or friend—will admit the inconvenient truth.

What could have been done differently by the producer?

An agent dealing with a risk he or she doesn't frequently handle often results in problems because the agent is unfamiliar with what coverages the client needs or what is and is not covered by the insurance policy. Here, that was not a problem because Dan recognized that his client had a pollution risk to address, and was aware the CGL did not address the risk. However, his lack of involvement in risks of this type likely was a factor in his not having a market available to place pollution coverage.

What do you think was the outcome?

The claim was ultimately settled at the courthouse steps with a substantial contribution from the agent in excess of \$100,000. In addition, the agent's deductible applied to defense costs and they paid an additional \$5,000.

CASE STUDY—System Failure

What are the major issues in this case?

The agency was not completely familiar with the carrier's computer system, nor did it have a separate method of tracking whether policies were in effect for existing customers. Additionally, the agency issued a temporary insurance card without any explanation of the limited nature of that card's effect.

- Internal tracking of policies for existing customers
- Communication processes with the carrier
- Familiarization with carrier computer systems
- Issuance of temporary insurance card without explanation of its effect and scope

Generally, these types of minimum-limit auto policies can fall "under the radar" for CSRs and other agency employees. Agencies should be sure to communicate importance of attention to detail on all work, not just more complicated policies/customer needs.

What were the root causes of the loss?

- Lack of communication between the agency and the carrier
- Failure to fully understand carrier's computer system
- Failure to confirm policy effective prior to adding endorsement
- Failure to document/explain scope and effect of temporary insurance card to policyholder

What could have been done differently by the agency? By the producer?

TNT should institute communication processes with the carrier that serves to notify TNT when a policy is nonrenewed or cancelled. TNT's principals should also take the time necessary to become familiar with the carrier's computer system and be sure that the employees are fully trained on that system. If TNT's employees notice issues that could be problems – such as the system's allowance of addition of endorsements to expired or cancelled policies – those issues should be communicated to the carrier and a process for such communication should be in place.

Bob should have clearly advised Oliver of the limitations in scope and effect of the temporary insurance card and documented or memorialized this advice. TNT could create a form letter that should be sent with all temporary insurance cards to address this issue.

What do you think was the outcome?

At trial defense counsel for TNT successfully argued that the carrier failed to provide appropriate safeguards in its system to prevent adding an endorsement to a cancelled policy. The trial lasted a full week with the principle of TNT required to attend all proceedings. While there was no finding of liability against TNT, the agency carried a \$50,000 deductible that applied to claims expenses. While the result was positive this time, there is no guarantee that similar cases will receive the same result from other juries.

New Business - Agent of Record/Account Review Client Letter

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Client:

We are privileged you have selected XYZ Agency to handle your insurance needs effective January 1, 20XX. As we discussed in our meeting, you wish to remain with ABC Insurance Company until your policy renews on June 1, 20XX. You have signed an Agent of Record letter that allows us to service your policy until that time.

Since your policy was originally written through another insurance agency, it will be necessary for us to review the contract to determine if the coverage provided is adequate. We will do this within the next 10 days and advise you of our recommendations. Until we have performed this review, we cannot be responsible for errors or omissions that were committed by your prior agent.

Once again, thank you for placing your trust in XYZ Insurance. We will do our best to provide you with the protection you expect and level of service you deserve.

Sincerely,

Andy Agent

New Business - Premium Quotation/Additional Insured Requirements

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Client:

We are pleased to provide you with a premium quotation for your automobile insurance policy to be effective February 1, 20XX.

If you wish to purchase this policy, please complete the enclosed application and return it to our office with your check in the amount of \$250.00. It will also be necessary for you to furnish us with the following information:

- ❖ A copy of your current policy to verify prior insurance
- ❖ A copy of your driver's license
- ❖ A photograph of your vehicle that includes the license plate

If we do not receive these items by January 31, 20XX, we will be unable to provide you with a policy and this quotation will expire. No coverage is in effect at this time. Please be aware that this will serve as our only follow-up to this quotation and you are responsible for providing us with the above required information materials and affirmative instruction to procure coverage .

Feel free to contact our office if we can answer any questions for you.

Sincerely,

Andy Agent

New Business - Agent Unable to Procure Coverage Requested

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Client:

During our recent meeting, you expressed an interest in insuring your hand-built automobile for damage caused by a collision or upset.

We have contacted several insurance companies to see if they would be willing to write the insurance and have not been successful. ***We are therefore unable to place coverage at this time.*** You may wish to contact other insurers to determine if they are able to provide this coverage for you.

If we become aware of a market for this coverage in the future, we will inform you. We regret we were unable to help you with this matter.

Sincerely,

Andy Agent

New Business - Acknowledgement of Coverage Offer/Rejection

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Insurance Program

Dear Mr. Client:

We are privileged you have selected XYZ Agency to handle your insurance needs effective January 1, 20XX. We have ordered the policies from the insurance company and will deliver them as soon as they are received in our office.

To confirm our conversation, you have been provided with a premium indication for the following coverages, but have decided not to purchase them at this time. We will assume that your declination of these coverages applies to all future renewals unless you contact us about procuring them in the future. Here are the referenced coverage options:

- ❖ Directors and Officers Liability Insurance
- ❖ Employment Practices Liability Insurance
- ❖ Commercial Crime Insurance

Please sign the enclosed acknowledgment form and return it to our office no later than January 15, 20XX.

Once again, thank you for placing your trust in XYZ Insurance. We will do our best to provide you with the protection you expect and level of service you deserve.

Sincerely,

Andy Agent

ACKNOWLEDGMENT OF REJECTED COVERAGE

I understand and acknowledge that the following insurance policies have been offered to me and that I have decided not to purchase the coverage at this time:

Directors and Officers Liability Insurance
Employment Practices Liability Insurance
Commercial Crime Insurance

The potential financial impact of not having these important coverages has been explained to me and I realize that my rejection of these options may result in the denial of claims in the future. In addition, it is your responsibility to request quotations for these coverages on all future renewals.

Signed _____
Date _____

(NOTE: This is only a suggested form of coverage rejection and should be adapted to your agency and reviewed by your attorney prior to use.)

Cancellation - Change in Late Payment Notice for Direct Bill Policyholders

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

SENT VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Dear Mr. Client:

In the past, we may have contacted you when a payment on your insurance policy, billed to you by the insurance company, was overdue. We are changing our agency practice of noticing clients of non-payment on direct bill accounts. Effective immediately, we will no longer do so, and it is your responsibility to make premium payments on or before their due date in order to avoid cancellation of your insurance policy. Prompt payment of premiums due will ensure that you receive the protection you need in the event of a loss.

We hope you will understand that our agency cannot accept any responsibility for late payments to the insurance carrier. Thank for being a continued valued customer and if we can be of service to you, please don't hesitate to contact our office.

Sincerely,

Andy Agent

Non-renewal - Placement with Another Carrier

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Client:

We know you have recently been notified that your automobile policy with Terminator Insurance will not be renewed on its expiration date of June 1, 20XX. The reason the company is not willing to offer a renewal policy is that they have decided to discontinue writing this type of business in (state).

We regret any inconvenience this may cause you and we are attempting to replace coverage with another insurance company. We will notify you well in advance of the expiration date if coverage cannot be replaced with another insurer.

Meanwhile, if you have any questions, please don't hesitate to contact our office. We know that the termination of an insurance contract can raise concerns, and we are ready to answer any questions you may have.

Sincerely,

Andy Agent

Non-renewal - Unable to Replace with Another Carrier

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

We know you have recently been notified that your automobile policy with Terminator Insurance will not be renewed on its expiration date of June 1, 20XX. The reason the company is not willing to offer a renewal policy is that they have decided to exit this type of business in Your State.

Our agency does not currently have another market that writes your type of business. Therefore, **effective June 1, 20XX, we will no longer be able to offer insurance for your automobiles.** All coverage will cease on that date.

You should make arrangements to replace coverage with another agent or company. We have enclosed a summary of all claims paid under your policies for the previous five years. This should assist you in arranging replacement coverage.

We regret that this action is necessary, and we will provide assistance to you as you find an alternative insurance arrangement. Please call our office if you wish to discuss this situation.

Sincerely,

Andy Agent

Non-renewal (Claims-made form) - Unable to Replace/Offer of Extended Reporting Period

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Claims-made Professional Liability Policy

We know you have recently been notified that your professional policy with Terminator Insurance will not be renewed on its expiration date of June 1, 20XX. The reason the company is not willing to offer a renewal policy is that they have decided to exit this type of business in (state).

Our agency does not currently have another market that writes this type of business. Therefore, **effective June 1, 20XX, we will no longer be able to offer you professional liability policy.** All coverage will cease on that date.

You should make arrangements to replace coverage with another agent or company. We have enclosed a summary of all claims paid under your policies for the previous five years. This should assist you in arranging replacement coverage.

As we previously explained to you, your policy was issued on a claims-made basis, meaning coverage only applies to claims that took place after June 1, 20XX and are reported to the insurance company between June 1, 20XX and June 1, 20XX. In order to have coverage for claims that may have occurred prior to June 1, 20XX but that are not reported until after the policy expires, you must purchase an Extended Reporting Period coverage option. This will extend the time period in which claims may be reported to the company, although they still must have occurred between June 1, 20XX and June 1, 20XX.

The cost for this coverage option is \$1,200 and payment must be received with your request for coverage. **The deadline to exercise this option is August 1, 20XX.**

We are sorry we will be unable to provide assistance to you upon expiration of your policy. Please call our office if you wish to discuss this situation and purchase the Extended Reporting Period coverage option.

Sincerely,

Andy Agent

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Claims – What to Expect with a Claim

CLAIMS HAPPEN...

We're sorry it happened to you.

We want you to know what to expect now that you've had the misfortune of suffering a loss.



The Claims Process. The loss you reported has been sent on to your insurance company for handling. They are responsible for making the determination of whether your policy will apply to this claim and the amount that may be paid.

The Time Frame. Most claims are settled quickly, however there may be additional information the insurance company must request from you in order to process your claim. If you have not been contacted by the company within the next 72 hours, please call our office.

Your Part. Your policy may requirement you to perform certain duties within a specified timeframe, so please read the corresponding policy language. Also, respond promptly to any communication you receive from the insurance company or our office. This will help speed the claim process. Keep copies of any documents that may be important to settling your claim, such as police reports, receipts, or notes of conversations.

Our Part. One of the most important reasons to do business with XYZ Insurance is the assistance we provide when you've had a loss. Please feel free to call us at any point in the claim process. We're here to help!

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New Business – Delivery of Binder/Transfer of Account to CSR

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Client:

We are enclosing a binder of insurance effective January 15, 20XX.

Please note that the binder reflects the coverage you asked us to place on your behalf. As prior stated, we have not included physical damage coverage (Comprehensive or Collision) on the vehicle since you stated that you did not want to purchase this recommended protection.

Your account will be handled by Pat Peterson, and I am enclosing his business card for your future reference. Pat has been with our agency for over two years and provides outstanding customer service to our clients. Don't hesitate to contact him with any questions or concerns.

If you require any changes to your policy, please let Pat know.

If we can be of any further help with this or any other insurance need, please feel free to contact us.

Sincerely,

Andy Agent

New Business – Policy Delivery Notice

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Client:

We are pleased to enclose your new automobile insurance policy for the period January 15, 20XX to January 15, 20XX.

Please review the policy carefully and let us know if any changes are required. If you have any questions regarding the coverage provided or the limitations or restrictions in the policy, please call us.

As discussed earlier, you may recall that you did not wish to have physical damage coverage (Comprehensive or Collision) included in the policy as recommended.

We appreciate your business. Please don't hesitate to contact us if you have any other insurance needs that we may help you with.

Sincerely,

Andy Agent

Audit – Policy Delivery and Audit Notification

August 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Liability Policy

Dear Mr. Client:

We are enclosing your liability policy for the period September 1, 20XX to September 1, 20XX.

Please review your policy carefully and advise us immediately if any changes are needed. Please note that this policy has been issued with a provisional premium, meaning the actual final premium will be determined after the policy expires based on an audit of your (sales)(payroll) during the policy period.

If your (sales)(payroll) is lower than estimated, you may receive a refund. However, if (sales)(payroll) exceeds your estimate, you may owe the insurance company additional premium. Throughout the year you should periodically review this so you can plan your budget accordingly.

If you have any questions or concerns after reviewing your policy, please contact our office. We appreciate the opportunity to arrange this coverage on your behalf.

Sincerely,

Andy Agent

Audit – Audit Notification with Revised Premium

August 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Liability Policy

Dear Mr. Client:

We are enclosing a final audit for the above policy. You may recall that when the policy was issued, we asked that you estimate the payroll and sales that would occur during the period June 1, 20XX and June 1, 20XX.

Your original estimate for payroll was \$100,000 and for sales was \$250,000. The actual amounts were \$125,000 in payroll and \$275,000 in sales. Congratulations, you had a great year!

We have enclosed the invoice for the additional premium due of \$435.00. This payment is due no later than August 11, 20XX. If payment is not made within this time frame, your current policy may be cancelled. Please send your payment immediately to avoid cancellation of your protection.

If you wish to discuss this invoice, please feel free to contact our office.

Sincerely,

Andy Agent

New Business – Premium Indication Delivery

January 1, 20XX

Mr. Joe Prospect
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Prospect:

Thank you for requesting an automobile insurance price quote from our agency. A copy of the price indication is enclosed for your review. ***Before coverage can be placed, we will need you to provide us with:***

A copy of your driver's license;

Proof of prior insurance;

A completed, signed, and dated application (enclosed); and

A check in the amount of \$XX

Please note that **INSURANCE IS NOT CURRENTLY IN EFFECT** and coverage cannot be placed until we have received these items and notified you of acceptance by the insurance company.

If you have any questions, please don't hesitate to call our office.

Sincerely,

Andy Agent

Renewal – Request of Required Renewal Information

March 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Client:

Your automobile policy is due to renew on 6/1/XX. In order to keep your coverage current and obtain the best renewal price, we are in need of the following information:

- ❖ Current list of drivers including license number and state of issuance
- ❖ Current vehicle list including vehicle identification or serial numbers

We are enclosing a brief description of the coverage currently provided by this policy. Please review this summary and advise us of any changes that should be made, either at this time or at the renewal date.

In order to receive your renewal on time, it is important that we receive this updated information no later than 4/1/XX. If we can be of any assistance, please don't hesitate to contact our office.

Sincerely,

Andy Agent

Renewal – Binder and Invoice Delivery

May 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Client:

We are happy to enclose a binder of insurance for the renewal of the above policy effective June 1, 20XX. We have ordered the renewal from the insurance company, but in the event it does not arrive by the renewal date, this binder will serve as evidence of insurance until the policy is issued.

We have also enclosed our invoice in the amount of \$2,156.00. This is the estimated annual premium for the renewal policy. Payment should be made by the renewal date. If you wish to pay the premium on a monthly basis, please send a down payment of \$650.00 and we will be happy to arrange for premium financing.

It is our sincere pleasure to arrange this insurance on your behalf. If you should have any questions or concerns, please don't hesitate to contact our office.

Sincerely,

Andy Agent

Renewal – Policy Delivery

June 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Automobile Policy

Dear Mr. Client:

We are pleased to enclose the renewal of your automobile policy, which is effective June 1, 20XX.

As you requested, we have arranged to finance your premium with Lowrate Bank and you should have already received your payment coupons. Payments are due on the 15th of each month and must be made promptly to avoid cancellation of your policy.

Please review your policy carefully, including any limitations and restrictions, and let us know if any changes are necessary.

It is our sincere pleasure to arrange this insurance on your behalf. If you should have any questions or concerns, please don't hesitate to contact our office.

Sincerely,

Andy Agent

Renewal – Placement with Non-admitted Market

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Earthquake Policy

Dear Mr. Client:

Your insurance policy is due to renew on June 1, 20XX. In order for us to attained coverage as you have instructed, it is necessary for us to replace coverage with a non-admitted insurance company, since we have received a declination from three admitted companies.

When coverage is written with a non-admitted company, you lose the ability to collect from the state insolvency fund in the event the company is declared bankrupt. Any claims that are outstanding on the date of the insolvency would be your responsibility to pay.

Although many non-admitted companies are financially stable, we must advise you that the possibility exists that your insurance may be uncollectable in the event of a loss. In order to proceed with placement of coverage, we will require your signature on the enclosed authorization form. **If the form is not received, we will be unable to continue coverage for you beyond June 1, 20XX.**

We regret any inconvenience this may cause you, and welcome your comments or questions. Please don't hesitate to contact our office.

Sincerely,

Andy Agent

New Business – Coverage Quoted/Placed with Carrier Rated Below B+

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Homeowners Policy

Dear Mr. Client:

At your request, your coverage has been **[placed or quoted]** with **(name of company)**. This insurer is currently rated **(B (Fair) or less)** by A.M. Best Company, a leading monitor of the financial performance and stability of insurance companies. A rating by the A.M. Best Company is an indication of the insurance company's financial strength and operating performance, with the top rating being A++ (Superior).

Our agency, generally, does not place coverage through any insurer that has a rating of less than B+ (Very Good). However, based on our search of the insurance marketplace and with your authorization, we will place your coverage with **(name of company)** at the premium amount outlined in our proposal.

While A.M. Best Company's rating of **(name of company)** reported it was financially stable at the time it was reviewed, this is not a guarantee of future performance. We are not experts in the financial analysis of insurance companies. Should this company become unable to satisfy its obligation to pay claims; our agency will not be held responsible for the insolvency of the carrier.

Please sign below and return this letter. By signing, you acknowledge that you have read this letter and we have reported to you the current A.M. Best's rating is less than B+ for the insurance company you have selected to provide your coverage.

Date

Signature of Insured

Printed Name

Sincerely,

Andy Agent

New Business – Coverage Quoted/Placed with Surplus Lines Carrier

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Homeowners Policy

Dear Mr. Client:

At your request, your coverage has been **[placed or quoted]** with **(name of company)**. This insurer is currently a surplus lines company and is rated by A.M. Best Company, a leading monitor of the financial performance and stability of insurance companies. A rating by the A.M. Best Company is an indication of the insurance company's financial strength and operating performance, with the top rating being A++ (Superior).

Our agency, generally, does not place coverage through any insurer that is a surplus lines company. However, based on our search of the insurance marketplace and with your authorization, we will place your coverage with **(name of company)** at the premium amount outlined in our proposal.

While A.M. Best Company's rating of **(name of company)** reported it was financially stable at the time it was reviewed, this is not a guarantee of future performance. In addition, while **(name of company)** is authorized to provide insurance, it is a "surplus lines" insurance company. This means that you will not be able to collect from the state insurance guaranty fund in the event **(name of company)** becomes insolvent.

We are not experts in the financial analysis of insurance companies. Should this company become unable to satisfy its obligation to pay claims; our agency will not be held responsible for the insolvency of the carrier.

Please sign below and return this letter. By signing, you acknowledge that you have read this letter and we have reported to you the insurance company you have selected to provide your coverage is a surplus lines company.

_____ Date	_____ Signature of Insured
	_____ Printed Name

Sincerely,

Andy Agent

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New Business - Coverage Quoted/Placed with Unrated Carrier

January 1, 20XX

Mr. Joe Client
123 Main Street
Anywhere, US

SUBJECT: Homeowners Policy

Dear Mr. Client:

At your request, your coverage has been **[placed or quoted]** with **(name of company)**. This insurer is currently not rated by A.M. Best Company, a leading monitor of the financial performance and stability of insurance companies. A rating by the A.M. Best Company is an indication of the insurance company's financial strength and operating performance, with the top rating being A++ (Superior).

Our agency, generally, does not place coverage through any insurer that is not rated. However, based on our search of the insurance marketplace and with your authorization, we will place your coverage with **(name of company)** at the premium amount outlined in our proposal.

The fact that **(name of company)** is not rated is not necessarily an indication of financial instability or inability to pay claims. Without a rating, however, there is no practical way to evaluate its financial condition in relation to other insurance companies.

We are not experts in the financial analysis of insurance companies. Should this company become unable to satisfy its obligation to pay claims; our agency will not be held responsible for the insolvency of the carrier.

Please sign below and return this letter. By signing, you acknowledge that you have read this letter and we have reported to you the insurance company you have selected to provide your coverage is not rated.

Date	Signature of Insured
	Printed Name

Sincerely,

Andy Agent

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CANCELLATION AND NONRENEWAL PROCEDURES

Company Request—Nonpayment of Premium—Midterm

- **Notice of cancellation is received from carrier or premium finance company. (NOTE: Do not contact insureds to notify them that their premium is overdue).**
- **Update client file and suspense for 30 days for receipt of cancellation notice from carrier.**
- ***If the cancellation is on a claims-made policy, send form letter offering Extended Reporting Period (tail) coverage and suspense for acceptance and receipt of premium.***
- ***If ERP is accepted and payment is received, REFER TO POLICY CHANGE PROCEDURES for processing.***
- ***If ERP is not accepted, send form letter to insured and document file.***
- **When cancellation is received from carrier, verify for accuracy and update client file.**
- ***If policy is auditable, REFER TO POLICY AUDIT PROCEDURES.***
- **Clear suspense.**
- **Contact client and perform exit interview.**
- **If this was the only policy the client had with the agency, make client inactive and place in dead file.**

CANCELLATION AND NONRENEWAL PROCEDURES

Carrier Request—Mid Term

- **Notice of intent to cancel is received in the agency from the carrier.**
- **Open client file and document.**
- **Contact insured and advise if an attempt will be made to replace coverage with another carrier.**
- ***If coverage is being replaced, REFER TO NEW BUSINESS PROCEDURES.***
- ***If the agency does not wish to search for and find an alternative market or is unable to replace coverage, forward appropriate form letter to insured. Suspend for cancellation date of policy.***
- **On policy cancellation date, send confirmation to insured. If this is the only policy for the client, make inactive and dead file or suspend for prospect activity as appropriate.**
- ***If the cancellation is on a claims-made policy, send form letter offering Extended Reporting Period (tail) coverage and suspend for acceptance and receipt of premium.***
- ***If ERP is accepted and payment is received, REFER TO POLICY CHANGE PROCEDURES for processing.***
- ***If ERP is not accepted, send form letter to insured and document file.***
- **Clear suspend.**

CANCELLATION AND NONRENEWAL PROCEDURES

Carrier Request--Nonrenewal

- **Nonrenewal notice is received from carrier.**
- **Open client file and document.**
- **Contact insured and advise if an attempt will be made to replace coverage with another carrier.**
- ***If coverage is being replaced, REFER TO RENEWAL PROCEDURES.***
- ***If the agency does not wish to search for and find an alternative market or is unable to replace coverage, forward appropriate form letter to insured. Suspend for expiration date of policy.***
- **When policy expires, send confirmation to insured. If this is the only policy for the client, make inactive and dead file or suspend for prospect activity as appropriate.**
- ***If the nonrenewal is on a claims-made policy, send form letter offering Extended Reporting Period (tail) coverage and suspend for acceptance and receipt of premium.***
- ***If ERP is accepted and payment is received, REFER TO POLICY CHANGE PROCEDURES for processing.***
- ***If ERP is not accepted, send form letter to insured and document file.***
- **Clear suspend.**

CANCELLATION AND NONRENEWAL PROCEDURES

Cancellation at Insured's Request—Mid-term

- Insured requests cancellation by phone, fax, mail or e-mail.
- Open client file and update information.
- Prepare ACORD cancellation request and forward to named insured (or first named insured) for signature using Cancellation Request form letter. (NOTE: This step is not necessary if insured has returned original policy along with cancellation request). It is not necessary to create a suspense for return of the cancellation request.
- If signed cancellation request is received from insured, forward to carrier with request for cancellation.
- Update client file. (NOTE: This is critical since any subsequent claim or request for service may be refused due to policy cancellation status).
- Suspense for 30 days for receipt of cancellation from carrier.
- When cancellation is received from carrier, verify for accuracy, update client file and create credit invoice if necessary. Transmit to insured and perform exit interview.
- *If policy is auditable*, REFER TO POLICY AUDIT PROCEDURES.
- Transmit cancellation confirmation and return premium to insured.
- *If policy is written on a claims-made form*, prepare offer letter for Extended Reporting Period (tail) coverage and forward to insured. Suspense for acceptance and receipt of premium, based on the policy form.
- *If ERP is accepted*, REFER TO POLICY CHANGE PROCEDURE for processing.
- *If ERP is not accepted*, send insured confirmation and document file.
- Clear suspense.
- If this was the only policy the client had with the agency, make client inactive and place in dead file or suspense for future prospecting activity.

CERTIFICATE OF INSURANCE PROCEDURES

- **Insured or third party contacts agency to request certificate.**
- **Open client file and document. Determine appropriate ACORD form (Certificate, Evidence of Property Insurance, etc.)**
- **If an endorsement to the policy is required, REFER TO POLICY CHANGE PROCEDURE.**
- **If certificate involves a special request (nonstandard form, unusual wording, form modifications, etc.), contact carrier for permission to deviate from standard form. Document file with name of person spoken to, date, and time.**
- **Issue certificate and forward to all parties of interest.**
- **Follow carrier procedure for distribution of certificates. (NOTE: Many carriers no longer accept certificates of insurance, making the agency responsible for any errors in the certificate. All requests for certificates under these circumstances must be handled with extreme caution.)**

CLAIMS PROCEDURES

(All Claims except Workers Compensation)

- **Agency is contacted that a claim has occurred. (NOTE: If notice of loss is received from anyone other than an insured, contact insured for verification.)**
- **Open client file and complete appropriate ACORD loss notice.**
- **Transmit loss notice to carrier immediately.**
- **Suspense for 3 days to perform client follow-up, if appropriate.**
- ***If client contact after three days is appropriate*, contact insured to determine current status of claim.**
- **Contact carrier if necessary.**
- **Update claim file.**
- **Suspense for 60 days for resolution of claim.**
- ***If claim is settled within 60 days*, update file with closing claim information and clear suspense.**
- **If claim check or draft is received by agency, transmit to insured the same day using form letter.**
- ***If claim is not settled within 60 days*, contact carrier to determine current status and re-suspense for 60 days.**
- **If claim is not settled after 120 days, notify management to take appropriate action.**
- **When claim is resolved, update client file and clear suspense.**

NOTE: Any summons and complaint or other legal papers received on any claim must be transmitted to the carrier via overnight mail the day they are received in the office to avoid any default judgment being entered against our insured.

NEW BUSINESS PROCEDURES

- Prospect calls in to agency and is directed to appropriate agent for evaluation or quotation. Agent determines eligibility, per individual company and agency underwriting guidelines, and proceeds with quote if appropriate. Appropriate underwriting information is obtained.
- Prospect is created in agency management system.
- Quote is prepared and prospect is advised of need for any further information or documentation that will be required prior to binding coverage or issuing policy. Quote letter is sent to prospect.
- Suspense for 30 days or effective date of quote, whichever is earliest.
- Activity created in agency management system.
- *If no action taken by prospect in 30 days, change to Suspect in system and send letter confirming coverage not placed. No further action necessary.*
- *If prospect wishes to purchase, appointment is set by agent to complete and sign application and obtain necessary underwriting information/documentation.*
- If necessary, re-rate based on current documentation and provide prospect with updated quote. Advise that if documentation is provided, an endorsement will be issued to the policy.
- *If application is complete and payment is received, coverage is bound by agent. (NOTE: Agent is responsible to determine binding authority with carriers and must not exceed expressed authority.)*
- *If coverage is placed with a nonadmitted carrier, REFER TO SURPLUS LINES NEW BUSINESS AND RENEWAL PROCEDURE.*
- Convert Prospect to Customer in agency management system. Create ID cards, Evidence of Property Insurance, or other items and deliver to client and/or lender, bank, additional insured, etc.
- Application, payment, and pertinent documents are transmitted to carrier immediately using company memo. Activity created in system and suspense set for 30 days for receipt of policy.

- **Create paper file for permanent records or scan and attach to client e-file.**
- **Send thank you note to customer.**
- **When policy is received from company, either via download or by mail, open customer file and update application by entering policy number.**
- **Agent reviews policy against application and system information for accuracy. Items to check include:**
 - **Carrier and policy number**
 - **Named insured (make sure it is complete)**
 - **Description of operations**
 - **Type of entity (individual, corporations, LLC, etc.)**
 - **Effective and expiration dates**
 - **Retroactive date if claims-made policy**
 - **Rates and premiums**
 - **Minimum earned premium**
 - **Minimum premium**
 - **Limits of liability (including aggregates, if applicable)**
 - **Deductibles and self-insured retentions**
 - **Property valuation clauses (ACV, Replacement Cost, Agreed Amount)**
 - **Covered auto symbols**
 - **Classification codes and exposures bases**
 - **Experience modification (Workers Compensation only)**
 - **Description of property covered including scheduled items**
 - **Review all endorsements**
 - **Any unexpected endorsements?**
 - **Any restrictive endorsements?**
 - **Any missing endorsements?**
 - **Any reductions in coverage or increased deductibles?**
 - **Any state-specific endorsements missing?**
 - **Any endorsements requiring signature (e.g. UM waiver)?**
 - **Commission amounts**
- **Enter premium amount and bill if necessary.**
- **Send form letter to client along with policy or deliver policy (and bill if necessary).**
- **Clear suspense.**

POLICY AUDIT PROCEDURES

- When canceling, nonrenewing, or processing the renewal of a policy that is subject to audit, update client file.
- Suspense for 60 days for completion of final audit.
- If audit is not received after 60 days, request from carrier using company memo.
- When audit is received, verify for accuracy and create invoice if necessary.
- *If audit is incorrect*, contact carrier to determine appropriate course of action.
- *If audit is to be revised*, notify carrier in writing immediately to prevent collection activity. Suspense for 30 days for receipt of revised audit.
- Transmit audit documents and invoice to insured using standard form letter.
- Suspense for 5 days for receipt of premium. (NOTE: This is critical since the time frame for payment of audit premiums to the carrier is very short and any uncollectable amounts must be promptly returned if the agency desires that the company pursue direct collection).
- If premium is not received in 5 days, refer to accounting for possible direct collection activity. Update client file.
- *If audit is disputed by insured*, contact carrier to determine appropriate course of action. Immediately notify carrier in writing of dispute and suspense for 30 days for receipt of revised audit.
- Clear suspense.

POLICY CHANGE PROCEDURES

- Client contacts agency to make policy change. (NOTE: If change is requested by anyone other than a named insured, make no material changes to policy until confirmation is obtained from the insured.)
- Open client file and update client information. Review entire account for any impact the change will make on other policies (e.g. umbrella and excess liability) and for opportunities to cross-sell.
- Request policy change from carrier using company memo. (NOTE: if coverage is placed with a non-standard carrier, contact company by phone to obtain authorization for change since agency does not have binding authority).
- Confirm change request in writing with insured using form letter.
- Send ID cards, Evidence of Property Insurance, or Certificate of Insurance as applicable.
- Suspend for 30 days for receipt of endorsement.
- When endorsement is received from company, verify for accuracy and update client file.
- *If endorsement is incorrect*, request correction from carrier and forward appropriate documentation. Suspend for receipt of correction if necessary.
- *If incorrect endorsement was sent directly to insured by carrier*, notify insured that correction has been requested.
- Process billing, if necessary.
- Transmit endorsement and invoice to insured using form letter, including due date for premium payment.
- Clear suspense.

REINSTATEMENT PROCEDURES

- **Servicing agent or producer determines if reinstatement of a canceled policy is appropriate.**
- **Open client file and document.**
- **Request reinstatement from carrier and suspense for 30 days for receipt of reinstatement confirmation.**
- **If there is a lapse in coverage, notify insured that there is a gap in coverage.**
- **If there is a lapse in coverage on a claims-made policy, prepare offer of Extended Reporting Period (tail) coverage and send to insured.**
- **If ERP is accepted and payment is received, REFER TO POLICY CHANGE PROCEDURE.**
- **If ERP is not accepted, document file.**
- **When reinstatement is received, check for accuracy of dates and document file as appropriate.**
- **Clear suspense.**

RENEWAL PROCEDURES

- 120 days prior to renewal, expiration list is generated and distributed to servicing agent and producer.
- Servicing agent reviews entire client file to determine if changes are required on renewal.
- Servicing agent determines special renewal/marketing considerations (moving to new carrier, competition, coverage upgrade, etc.) and updates client file.
- 90 days prior to renewal, contact insured (letter, phone, fax, or e-mail) to:
 - Advise that policy is expiring
 - Ask if there have been any changes in exposures
 - Request any additional information required by carrier
 - Provide an indication of renewal premium
 - Obtain current list of property, vehicles, drivers, etc.
- *If coverage is being replaced with another carrier* (marketed or quoted elsewhere), REFER TO NEW BUSINESS PROCEDURES.
- Suspend for 10 days for receipt of renewal information from insured.
- *If renewal information is received*, update client file and request necessary changes from carrier (NOTE: If coverage is to be added or increased, make the change immediately on the current policy and request the same change on the renewal).
- *If coverage is being renewed with a nonadmitted carrier*, REFER TO SURPLUS LINES NEW BUSINESS AND RENEWAL PROCEDURES.
- Suspend for 30 days prior to renewal for receipt of policy.
- *If renewal information is not received*, contact insured to follow up and re-suspend for 10 days.
- *If policy is not received 30 days in advance of renewal*, send second request to carrier and re-suspend for 10 days.
- Prepare binder and invoice to be sent to insured 30 days prior to renewal.

- **When renewal policy is received, check against application, expiring policy and correspondence for accuracy, including:**
 - **Carrier and policy number**
 - **Named insured (make sure it is complete)**
 - **Description of operations**
 - **Type of entity (individual, corporations, LLC, etc.)**
 - **Effective and expiration dates**
 - **Retroactive date if claims-made policy**
 - **Rates and premiums**
 - **Minimum earned premium**
 - **Minimum premium**
 - **Limits of liability (including aggregates, if applicable)**
 - **Deductibles and self-insured retentions**
 - **Property valuation clauses (ACV, Replacement Cost, Agreed Amount)**
 - **Covered auto symbols**
 - **Classification codes and exposures bases**
 - **Experience modification (Workers Compensation only)**
 - **Description of property covered including scheduled items**
 - **Review all endorsements including:**
 - **Any new or unexpected endorsements?**
 - **Any reductions in coverage or increased deductibles?**
 - **Any missing endorsements?**
 - **Any state-specific endorsements missing?**
 - **Any endorsements requiring signature by insured?**
- **Adjust invoice if necessary and update client file.**
- **Prepare a transmittal letter to the insured.**
- ***If premium is unpaid, refer to accounting.***
- **Mail or deliver the policy**
- **Clear suspense**
- ***If renewal is not accepted by client, REFER TO CANCELLATION AND NONRENEWAL PROCEDURES—INSURED’S REQUEST***

SURPLUS LINES NEW BUSINESS AND RENEWAL PROCEDURES

- **Agency determines that coverage may be placed in the nonadmitted market after completing diligent search of the standard market.**
- **Create paper file for maintenance of surplus lines documentation.**
- **Notify insured of placement in nonadmitted market and request acknowledgment using appropriate form.**
- **Forward application and request for coverage to the surplus lines broker. Suspense for 10 days for receipt of binder, cover note, or other confirmation that coverage has been affected.**
- **When policy is received from the surplus lines broker, REFER TO NEW BUSINESS OR RENEWAL PROCEDURES.**
- **If necessary, file appropriate documents with the Department of Insurance or surplus lines association.**
- **Suspense for receipt of acknowledgment of filing from Department or Association.**
- **When acknowledgment is received, document file.**
- **Clear suspense.**