

CHAPTER 2 INSURANCE COMPANIES AND DISTRIBUTION SYSTEMS

TYPES OF INSURERS

The organization to which an insured transfers the risk of loss is known as the insurance company—also known as the insurer, carrier, or principal. According to the code, any person capable of making a contract may be an insurer subject to the restrictions imposed by the code. (CIC 150) The three main providers of insurance are private commercial insurers, private noncommercial insurers, and the government. Commercial insurers are in business to make a profit. Private noncommercial insurers operate on a nonprofit basis meaning any profits are returned to the insureds by way of lowered premiums or expanded benefits. Stock and mutual insurers are the two main types of private insurers although other forms of private insurers include fraternal, reciprocal, Lloyd's, self-insurers, and reinsurers.

Stock insurers are corporations organized for the purpose of making a profit for their stockholders. A stock company raises money by selling shares of stock; the stockholders are the owners of the company; and the affairs of the company are handled by a board of directors elected by the stockholders. The type of policy issued by stock companies is called **non-participating** (non-par) as the policyholders do not share in the company's profits. When declared, **divisible surplus is returned to the stockholders as shareholder dividends.**

Mutual insurers are corporations owned by the policyowners. When a person buys an insurance policy from a mutual insurer that person is becoming an owner in the company as well as a policyholder. As an owner, the policyholder votes for the board of directors. The policies issued by mutual insurers are referred to as **participating** (par) policies as **any divisible surplus is returned to the policyowner in the form of a policyholder dividend.** Surplus can be defined as excess earned or saved by the insurance company. Earned surplus is generated by:

- Mortality-----fewer people die than expected
- Interest-----company earns more interest than assumed
- Expenses---company overhead is less than projected

Dividends are regarded by the federal government as a return to the policyowners of excess premiums charged for the insurance coverage. As such, dividends paid by mutual insurers are not taxable income. However, it also should be noted that dividends cannot be guaranteed as surplus will vary from year to year.

Assessment mutual insurance companies are distinguished by the manner in which they handle premiums. In a pure assessment mutual insurance

company, no premiums are paid in advance; rather each member is assessed a portion of the losses actually experienced by the company. With an advance premium assessment mutual insurer, a premium is paid at the beginning of the policy period. If the company has a surplus, it is returned to the policyholders in the form of a dividend. If the company does not have adequate funds to cover losses, policyholders may have additional assessments levied against them. Usually any additional assessment is limited either by state law or the company's own bylaws.

An incorporated mutual insurer may be converted into an incorporated stock insurer. The process whereby a mutual insurer becomes a stock insurer is known as **demutualization** or conversion. (CIC 11535)

Reciprocals (interinsurance exchanges) are unincorporated associations of individuals known as subscribers who agree to insure one another. Each subscriber is allocated a separate account in which his/her premiums and interest are recorded. If any subscriber sustains a covered loss, every subscriber's account will be assessed to pay the claim. A reciprocal is managed by an attorney-in-fact who handles the business of the reciprocal and who is normally overseen by an advisory committee of subscribers.

Fraternal insurers (fraternal benefit societies or fraternal) are life insurance carriers that are social organizations that normally are involved in charitable activities. Fraternal societies usually are incorporated without capital stock. To be considered a fraternal, the organization must be nonprofit, must have a lodge system with a ritualistic form of work involved, and have an elective form of government. Fraternal society insurance provides benefits for sickness, accident and death and such insurance may be sold only to members of the society for the benefit of its members and their families.

Lloyd's of London is not an insurer but an association of individuals who are grouped into syndicates that underwrite risks. Each individual or syndicate is individually responsible for the amounts of insurance underwritten. Lloyd's provides a meeting place and clerical services to its members. Lloyd's also assures the performance of its members by means of a governing committee and enforcing its rules of eligibility. There are Lloyd's Associations in the United States. Lloyd's provides coverage for both large and unusual risks that might not be available in the normal insurance market.

Self-insurers do not purchase insurance but rather retain the risk. A self-insurer will establish its own reserves to pay for potential losses. In order to self-insure a company would need a means of predicting possible losses and have sufficient assets to cover costs. Some companies may choose to self-insure for auto insurance, health insurance, or workers compensation insurance. The advantage of this is that a company may experience savings if losses are few, but a disadvantage is losses could be higher than expected. Frequently self-

insurers will have an insurance contract with an insurance company to provide insurance above a certain level of loss.

Reinsurers are insurance companies that assume some or all of a risk written by a primary carrier which is referred to as the **ceding company**. Companies will set **retention limits**—that is, a maximum amount that they wish to retain on an insurance contract. If a company writes a policy for an amount more than the retention limit, it will cede anything above that amount to a reinsurer. Reinsurance treaties are an arrangement among the companies in which the companies share the risk and the premium proceeds. Policyowners do not need to know about reinsurance as the originating company will issue the check for the entire claim. The reinsurers will reimburse the originating company for their share of the reinsured amount.

Reinsurance can be written on either a facultative or treaty basis. Under the treaty basis, two or more companies agree to share large risks. The contract requires the reinsurer to automatically accept risks of a certain type(s) written by the ceding company subject to the reinsurance contract specifications. In a facultative reinsurance arrangement, the reinsurer will evaluate each individual risk offered by the ceding company and make a decision to either accept or reject the offered risk.

There are a number of reasons for companies to reinsure. Some reasons are as follows:

- ❑ Expand its capacity
- ❑ Finance its expanding volume
- ❑ Stabilize its underwriting results
- ❑ Secure catastrophic protection against large (shock) losses
- ❑ Share large risks with other companies
- ❑ Withdraw from a class or line of business or a geographical area within a short period of time

Service providers are technically not insurers but are organizations offering health care services. These providers offer prepaid plans for hospital, medical, and surgical expenses and include Blue Cross/Blue Shield organizations, health maintenance organizations (HMOs), and preferred provider organizations (PPOs). These groups do not pay monetary benefits to the plan subscribers; they pay benefits to the provider (hospital or doctor) of medical services.

GOVERNMENT AS AN INSURER

Both the federal and state governments are insurers providing a variety of insurance programs. The federal government provides insurance for catastrophic exposures as well as social insurance. These are areas that the

private insurers do not wish to be involved. The social areas involve Social Security and Medicare. The federal government also offers Serviceman's Group Life Insurance and Veterans' Group Life Insurance. Other coverages offered by the federal government include War Risk Insurance, National Flood Insurance, Nuclear Energy Liability Insurance, Federal Crop Insurance, Federal Crime Insurance, and insurance on mortgage loans (FHA).

California state government is involved in insurance too. Some areas are Medi-Cal (health benefits for the needy), unemployment insurance, state disability insurance, the California Earthquake Authority, and California State Compensation Insurance Fund (workers compensation).

Government insurance differs from private insurance in that benefits are prescribed by law, the benefits are meant to be adequate to meet the needs of the public rather than being equitable, and participation is mandatory for eligible citizens. In private insurance, a person will decide what benefits he/she needs and can afford and will be issued an individual insurance contract stating such benefits.

DOMESTIC, FOREIGN, AND ALIEN INSURERS

Companies may be classified according to where the company is domiciled meaning where the company has its principal legal residence, where it was organized, or where it was incorporated.

A company is considered to be a **domestic** insurer in the state where it was organized. Therefore, any company organized under the laws of the state of California is considered to be a domestic insurer in California, whether or not it is admitted to do business in California.

A **foreign** insurer is an insurer organized under the laws of another state within the United States, whether or not it is admitted to do business. Thus, a company organized in Arizona is considered to be a foreign insurer in California.

An **alien** insurer is an insurer organized under the laws of any jurisdiction other than a state of the United States, whether or not admitted to do business in California. For instance, a company organized in Canada is considered alien.

ADMITTED AND NONADMITTED INSURERS

A company wishing to transact business in California must be admitted or approved to do business by the Department of Insurance. An admitted insurer receives a Certificate of Authority from the insurance commissioner allowing it to transact specified classes of insurance in California. An admitted company may be domestic, foreign, or alien. All companies not holding such a certificate are considered nonadmitted insurers and are not entitled to transact business in

California. Other terms meaning admitted and nonadmitted are authorized and unauthorized.

RATING SERVICES

Insurance companies are rated by several different services. Public libraries should have this information. A.M. Best specializes in analyzing the insurance industry. Insurance companies are required to submit financial statements with various government agencies and these reports are public. A.M. Best uses this information to rate the companies and charges the insurers for this service. A.M. Best rates the companies by size, type, and financial soundness including the ability to pay claims. Best rates companies from A++ (superior) to F (in liquidation).

Other rating services that rate insurance and non-insurance companies are Moody's Investors Service, Standard & Poor's Rating Group, and Fitch Ratings. These services rate companies on their ability to pay claims. Another newer rating service is Weiss Research. These companies may be contacted at the following addresses:

A.M. Best Company
Ambest Road
Oldwick, NJ 08858 (908) 439-2200

Moody's Investors Service
99 Church Street
New York, NY 10007 (212) 553-0448

Standard & Poor's Rating Group
55 Water Street
New York, NY 10041 (212) 438-2000

Fitch Ratings
33 Whitehall Street
New York, NY 10004 (212) 908-0500

Weiss Research, Inc.
4400 Northcorp Parkway
Palm Beach Gardens, FL 33410 (800) 291-8545

CLASSES OF INSURANCE WRITTEN

An insurer cannot transact any class of insurance without first being admitted. It also cannot transact any class of insurance that is not authorized by its articles of incorporation or its charter. Thus insurers may be classified by the

classes of insurance they transact. Some products sold by insurers are property insurance, casualty insurance, health insurance, life insurance, and annuities.

Property insurance covers a wide variety of potential losses to both personal and business property. Property insurance covers personal possessions, buildings, inventory, stock, and many other related losses such as business income and business interruption.

Casualty insurance is primarily to cover the liability of an individual or organization that results from a negligent act or omission resulting in bodily injury or property damage of another party. Some coverages falling under this category are automobile liability, workers compensation, equipment breakdown, crime, and general liability insurance.

Health insurance, also referred to as disability insurance, includes a number of forms of insurance to protect the insured from financial loss caused by either sickness or accident. These policies cover the financial costs of treatment for sickness or accident or may provide an income for a person disabled by sickness or accident. These policies may be written on either an individual or group basis.

Life insurance is to protect the insured from dying prematurely. It provides a sum of money to a beneficiary upon the death of the insured. Beneficiaries could be a person, business, organization, or estate of the insured.

Annuities are not insurance but are a product sold by life insurance companies that pay an income benefit for the life of the annuitant. Typically benefits are paid at retirement age and are guaranteed to pay either a fixed or variable income.

CALIFORNIA INSURANCE LAW

The body of law regulating the insurance industry is the Insurance Code. The state legislature is responsible for writing the code. Therefore, any changes to the code must be made by the state legislature. A bill must be passed and presented to the governor for consideration. If the governor does not take action on the bill within a specified number of days, it automatically becomes law.

The Department of Insurance is the agency that is responsible for enforcing the code. The insurance commissioner, an elected public official who may serve two **4-year** consecutive terms, heads up the Department of Insurance (DOI). The commissioner may institute rules and regulations, known as California Regulations (CCR), to carry out the code. The commissioner also may change or withdraw these regulations. These rules and regulations are part of the California Administrative Code. The regulations explain how the code is to be

administered and they reference the section of the code to which they apply. Even though the CCRs are not law, they carry the same weight as law.

Among the commissioner's duties are:

- The licensing and supervision of insurance producers;
- The licensing and supervision of domestic insurers;
- Deciding which insurance companies are admitted to do business;
- Deciding the kinds of policies and insurance contracts that may be sold;
- Determining the amount of reserves that an insurer must maintain;
- Regulating the type of investments an insurer may make;
- Investigate consumer complaints against insurers and producers;
- Submit an annual report to the governor regarding the state of the insurance business in the state of California.

It should be noted that the interpretation of policy provisions is not a primary objective of insurance regulation.

One of the major concerns of the commissioner is the solvency of any company transacting business in the state. There are regulations governing the organization and ownership of a new company, capital and surplus requirements, reserves, investments, and annual reports.

As insurers collect a great deal of premium to cover potential losses, it is of utmost importance to guard against insolvency. The commissioner must conduct a financial examination of every admitted insurer at least every five years. Such examinations entail a complete review of financial affairs and general business records of the insurer. The commissioner may do an examination of an insurer any time if needed to protect the public interest. Another type of investigation that the commissioner may do is a market conduct examination. This would check the insurer's accuracy and organization of forms and records as well as advertising materials, claims procedures, and policyowner relations.

It is important to guard against misleading advertising. The NAIC developed an Advertising Code to help guard against such advertising. This code specifies words and phrases that cannot be used in advertising materials as well as requiring the full disclosure for policy renewal, cancellation, and termination provisions.

The NAIC also developed the Unfair Trade Practices Act which gives commissioners the authority to investigate insurers and producers and, if warranted, issue cease and desist orders and level penalties. Commissioners also have the power to obtain a court injunction to restrain insurance companies from using any unfair or deceptive methods.

FINANCIAL STATEMENTS AND INVESTMENTS

On or before March first all insurers transacting business in California must submit a report to the commissioner stating their financial condition as of the preceding December 31st. Insurers are required to have an annual audited financial report done by an independent CPA done in conformity to the standards set by the National Association of Insurance Commissioners (NAIC). Information included in the annual report will be capital, capital stock and assets, liabilities, income, expenditures, balance sheet of premium note accounts, balance sheet of all business, total amount of insurance written during the year on new policies, total amount of insurance written during the year in California, and total amount of premiums received on business in California. All securities and properties must be valued as required by the code.

An insurance company must have assets equal to the sum of its liabilities and the minimum level of capital and surplus required for admission. The amount that an insurer's assets exceed its liabilities is known as surplus. Policy dividends are paid from an insurance company's surplus. Insurers may invest assets as long as they conform to state law. According to California Insurance Code 1170-1182, the investments insurers are allowed to make with their assets are as follows:

- County, municipal, and school district obligations of this state, any other state, Canada, or Puerto Rico
- Obligations of the United States, Canada, and Puerto Rico
- State obligations of this state or any other state
- Real estate mortgages
- County water district bonds
- Obligations of the U.S. Postal Service
- Collateral trust bonds and notes
- Accounts in banks, savings and loan associations, or credit unions

The National Association of Insurance Commissioners is the U.S. standard-setting and regulatory support organization governed by the insurance commissioners of the 50 states, District of Columbia, and five U.S. territories. It acts as a forum to create model laws and regulations. Each state decides whether or not to pass each model act or regulation. The NAIC concerns itself with insurance regulatory matters but does not actually regulate. It has established the statutory accounting principles upon which insurance accounting is based. The standard accounting principles are notable for its very conservative valuation methods. The NAIC's Securities Valuations Office is responsible for the day-to-day credit quality assessment and valuation of securities owned by state regulated insurance companies.

Every insurer doing business in California shall annually, by the first day of March, file with the NAIC a copy of its annual statement. Quarterly statements

also must be filed by January 1, May 15, August 15, and November 15. The insurance commissioner may suspend, revoke, or refuse to renew the certificate of authority of any insurer failing to file its annual or quarterly statement with the NAIC. (CIC 930-934)

INSURER SOLVENCY

Insolvency means any impairment of minimum “paid-in capital” required of an insurer for the class(es) of insurance which it transacts. An insurer cannot escape the condition of insolvency by being able to provide for all its liabilities and for reinsurance of all outstanding risks. An insurer must also be possessed of additional assets equivalent to such aggregate “paid-in capital” required by the code after making provision for all such liabilities and for such reinsurance. (CIC 985)

Paid-in capital is capital received from investors in exchange for stock as distinguished from capital generated from earnings or donated. According to the code, a foreign mutual insurer must have the value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks plus its paid-in capital must be composed of available cash assets amounting to at least \$200,000. In the case of other insurers, they must possess the lower of the following amounts:

- (1) The value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks.
- (2) The aggregate par value of its issued shares of stock, including treasury shares. (CIC 36)

Even with all of the regulatory controls, an insurer may experience financial difficulty. If this were to happen, the Department of Insurance (DOI) has the authority to step in and assume control over the company’s funds and management. If an insurer were to become impaired (suffering financial problems) or insolvent (cannot meet financial obligations), the DOI will try to rehabilitate the insurer. To rehabilitate or conserve means to restore the insurer to financial soundness.

Conservation means the commissioner thinks an insurer can be saved from insolvency. The commissioner may apply to the superior court of the county in which the insurer has its principal office and become the conservator of the business. The commissioner will take over the insurer’s assets, property, books, and records and run the business. The following are grounds for the commissioner to take over an insurer:

- a. The company has refused to submit books, papers, or accounts to the commissioner for inspection.

- b. The company has neglected or refused a commissioner's order to make good any deficiency in its capital (stock company) or reserves (mutual company).
- c. Without getting the commissioner's written consent, the company transfers or tries to transfer all its property or business to another person or consolidates its property and assets with another business.
- d. After an examination by the commissioner, the company is found to be in such bad financial condition that continuing to conduct its business is hazardous to the public, creditors, or policyholders.
- e. The business entity has violated its charter or state law.
- f. Any officer of the business refuses to be examined under oath about the company's affairs.
- g. An officer or attorney in fact has wrongfully diverted or embezzled any of the company's assets.
- h. A domestic insurer does not comply with the state's requirements for a certificate of authority or that the company's certificate has been revoked.
- i. The insurer was found to be insolvent at its last examination by the insurance department. (CIC 1011)

Whenever the above conditions exist or it appears that irreparable loss and injury to property or business may occur, the commissioner, without notice and before applying to the court for any order, shall take possession of the property, business, books, records and accounts and of the offices and premises occupied for the transaction of business and retain possession subject to the order of the court. Any person having possession of and refusing to deliver any of the books, records or assets of a person against whom a seizure order has been issued, shall be guilty of a misdemeanor and punishable by fine not exceeding one thousand dollars or imprisonment not exceeding one year, or both such fine and imprisonment. (CIC 1013)

Liquidation means the commissioner feels it would be futile to proceed as conservator of the insurer and applies to the court for an order to liquidate and wind up the business of the insurer. (CIC 1016)

GUARANTEE ASSOCIATIONS

California has two guarantee associations—the California Life and Health Insurance Guarantee Association to which all life and health insurers must belong and the California Insurance Guarantee Association to which property and casualty insurers must belong with a few exceptions. The authority to transact insurance in the state is contingent upon these insurers being a member of the appropriate association.

California Life and Health Insurance Guarantee Association (CIC 1067-1067.18)

The purpose of the California Life and Health Insurance Guarantee Association is to protect policyowners, insureds, and beneficiaries against loss when a member company is financially impaired and cannot pay its contractual obligations under life insurance, health insurance, and annuity contracts. To provide this protection, an association of insurers is created to pay benefits and members of the association are subject to assessment to provide funds. All admitted life and health insurers are obligated to join this association. The association is managed by a board of directors and shall consist of not less than 9 nor more than 13 member insurers. The members of the board shall be selected by member insurers and approved by the commissioner.

The protection of the association extends to persons who are owners of policies or certificate holders and who are residents of this state. The association also provides coverage to nonresidents if all of the following conditions are met: (1) the insurer that issued the policy is domiciled in this state; (2) the insurer never held a license or Certificate of Authority in the state in which the person resides; (3) the state in which the person resides has an association similar to the association that exists in California; and (4) the person is not eligible for coverage by the association in the state of residence.

If an impaired member is a domestic company, the association may do one of the following after receiving the commissioner's approval:

1. Guarantee, assume or reinsure the impaired company's policies or contracts.
2. Provide monies, pledges, notes, guarantees or other means to ensure payment of an impaired insurer's obligations.
3. Loan money to the impaired company.

To provide funds to run the association, the association may assess the member insurers for the necessary amounts. If an insurer does not pay the assessment when due, it is subject to having its certificate of authority suspended or revoked by the commissioner.

The contracts covered by the guarantee association are direct, non-group life, health, annuity, and supplemental policies or contracts and certificates under direct group life, health, annuity, and supplemental policies and contracts. Coverage is not provided for:

- Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policyholder.
- Any policy or contract of reinsurance, unless assumption certificates have been issued.
- Any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds statutory limitations.

- Guaranteed investment contracts, guaranteed interest contracts, funding agreements, deposit administration contracts, and all other unallocated annuity contracts.
- Any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured.
- Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the policyholder, in connection with the service to or administration of the policy or contract.
- Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a Certificate of Authority to issue the policy or contract in the state.
- Any annuity issued by a charitable organization that is duly qualified as such under applicable provisions of the Internal Revenue Code, and that is not engaged in the business of insurance as its primary business.

The benefits that the association may be liable to pay for any one life may not exceed the lesser of:

1. 80% of contractual obligations (subject to certain limitations);
2. \$300,000 in life insurance death benefits, but no more than \$100,000 in net cash surrender value for life insurance;
3. \$250,000 in the present value of annuity benefits, including net cash surrender values.

There is a maximum aggregate amount of \$300,000 in life insurance benefits with respect to any one individual no matter the amount or number of policies for which the association will assume liability.

With respect to any one owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation, or other legal entity, and whether the persons insured are officers, employees, or other persons in whose lives the policy owner has an insurable interest, the maximum benefit is \$5,000,000 regardless of the number of the policies and contracts held by the owner.

The health insurance benefits for which the association may become liable shall in no event exceed the lesser of the following:

1. The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not impaired or insolvent.
2. With respect to any one individual, regardless of the number of contracts, \$200,000 in health insurance benefits. This amount shall increase or decrease based upon changes in the health care cost component of the

consumer price index from January 1, 1991 to the date on which the insurer becomes insolvent.

TAXATION OF LIFE INSURERS

Life insurance companies are taxed on investment income and underwriting profit. However, a great deal of premium for life insurance is a deposit of policyowner funds and is not earned income of the insurer. The investment income for stock companies is taxed in the year it is earned and 50% of underwriting profit is taxed during the year earned while the other 50% is taxed when paid to the stockholders. Mutual insurers pay out their underwriting income as dividends to policyholders and, therefore, this tax regulation generally does not apply.

The state of California taxes insurers on premiums received by doing business in California. Every insurer transacting in California must file a premium tax return each year with the Department of Insurance.

California will impose a retaliatory tax on foreign and alien insurers if another state or country imposes taxes and fees on California insurers that are in excess of the taxes and fees imposed upon similar insurers by the state of California.

COMPANY OPERATING DIVISIONS

Within a company's organization are several managerial departments. Marketing and sales, actuarial, underwriting, claims, and administrative are such departments.

Marketing and sales is responsible for marketing the insurance product which includes advertising, promotion, and training.

Actuarial departments are responsible for the company's financial soundness. Actuaries analyze the data collected by the company. They are responsible for developing mortality and morbidity tables, preparing annual reports, and determining dividends as well as setting premiums and making sure the premiums are adequate.

Underwriting departments set standards for the selection of acceptable risks. Underwriters will evaluate the information collected on an insurance applicant and assess factors such as age, occupation, insurable interest, and degree of exposure to risk. Based on this information, they will decide to accept or reject an application. If acceptable, underwriters will decide whether the applicant is a preferred risk, standard risk, or substandard risk.

Claims departments receive claims, evaluate them, and settle them appropriately. Before a life insurance claim can be paid, a death certificate would have to be received by the insurance company.

Administrative departments will handle the issuing of policies, policy changes, billings, and other policy services.

TRANSACT

“Transact” as applied to insurance includes any of the following:

- (a) Solicitation (CIC 35[a])
- (b) Negotiations preliminary to execution (CIC 35[b])
- (c) Execution of a contract of insurance (CIC 35[c])
- (d) Transaction of matters subsequent to execution of the contract and arising out of it (CIC 35[d])

As noted above in the definitions section, a property/casualty insurance agent, life-only agent, accident and health agent, broker, and solicitor are licensed to transact various lines of insurance. A person shall not act in any of the capacities defined in transacting (solicitation, negotiation, execution, and transaction) unless he/she holds a valid license from the commissioner authorizing him/her to act in such capacity. (CIC 1631) Any person who acts, offers to act, or assumes to act in a capacity for which a license is required without a valid license is guilty of a misdemeanor **punishable by a fine not exceeding fifty thousand dollars (\$50,000) or by imprisonment in a county jail for a period not exceeding one year, or both fine and imprisonment. (CIC 1633)**

The unlawful transaction of insurance business by an insurer in willful violation of the requirement for a certificate of authority is a public offense punishable by imprisonment in the state prison, or in a county jail not exceeding one year, or by fine not exceeding one hundred thousand dollars (\$100,000), or by both that fine and imprisonment, and shall be enforced by a court of competent jurisdiction on petition of the commissioner. (CIC 700(b).

PRODUCERS

Producers are licensees who sell insurance products including agents, brokers, and solicitors.

An **agent** is appointed by an insurance company to sell its products and represents the insurer, not the insured. A **life-only agent** is authorized to transact on behalf of a life insurer (CIC 32) and may transact insurance coverage on human lives, including benefits of endowment and annuities, as well as benefits in the event of death or dismemberment by accident and benefits for disability income. (CIC 1626) An **accident and health agent** is authorized to

transact insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income as well as 24-hour coverage. (CIC1626) An accident and health agent who wishes to sell 24-hour care coverage shall complete a course, program of instruction, or seminar of an approved continuing education provider on workers' compensation and general principles of employer liability which shall be completed by an examination approved by the commissioner. This instruction must be completed prior to selling 24-hour coverage. (CIC 1749.33) Accident and health agents who wish to write applications for qualified health plans through Covered California must complete all Covered California agent agreements and certification requirements. To remain a **certified agent**, recertification is required every five years following initial certification. Accident and health agents do not have the authority to transact life, annuity, property or casualty insurance

An **insurance agent** is a person authorized, by and on behalf an insurer, to transact all classes of insurance other than life, disability, and health insurance. (CIC 31)

A **broker** is a person who is not appointed by an insurer, but rather for compensation acts on behalf of a client to transact insurance other than life, disability, and health insurance. (CIC 33)

A **solicitor** is a natural person employed by an insurance agent or broker to aid in transacting insurance, other than life, disability, and health insurance. (CIC 1624) Solicitors work in support of the sales efforts of the agent/broker who employs them. There is no such license as "life solicitor" or "accident and health solicitor. (CIC 1704(d)

A **life settlement broker** is a person who, on behalf of an owner and for a fee, commission, or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and providers. A life settlement broker represents only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions and in the best interest of the owner—not withstanding the manner in which the broker is compensated. (CIC 10113.1[b]), 10113.2(b){1}(a) to (d)

It should be noted that a broker is the representative of the insured and does the insurance shopping for the client. Brokers do not have appointments with insurers, but place business with admitted companies that will accept the offer made by the broker. A person may hold both an agent and broker license. Such a licensee is acting as an agent when placing business with a company with whom he/she has an appointment. When transacting insurance with a company with whom the licensee is not appointed, the licensee is acting in the capacity of a broker.

LIFE AND DISABILITY ANALYST

Life and disability insurance analyst means a person who, for a fee or compensation of any kind, paid by or derived from any person or source other than an insurer, advises, purports to advise, or offers to advise any person insured under, named as beneficiary of, or having any interest in, a life or disability insurance contract, in any manner concerning that contract or his or her rights in respect thereto. (CIC 32.5)

The license qualifications for an insurance analyst are as follows (CIC 1831-1849):

- Age 18 or older and a California resident.
- Makes a written application on a prescribed form.
- Answers under oath any questions asked by the commissioner.
- Has a good business reputation.
- Has thorough knowledge of life and disability insurance. No person shall be eligible for a life and disability insurance analyst license unless for five years preceding the date of the examination, he/she has worked as a life or disability licensee or as an employee of such a licensee.
- Has not been connected with any business transaction that shows unfitness to act in a fiduciary capacity.
- Has not willfully misstated any material fact in a license application or obtained a license by concealment or misrepresentation.
- Is a fit and proper person to hold a license.
- Does not seek the license to avoid or prevent enforcement of the insurance laws.
- Has passed the required examination.

A life and disability insurance analyst shall not receive any fee unless that fee is based upon a written agreement signed by the party to be charged. The agreement shall include a statement that the information and services concerning insurance policies may be obtained directly from the insurer without cost, an outline of the services to be performed for which a fee is charged, and the fee to be charged. Additionally, if the licensee is also licensed as a life agent, there shall be a statement indicating this fact. A copy of such agreement shall be retained for not less than three years after the services have been fully performed. (CIC 1848)

An employee or officer of any insurer is not eligible for license as a life and disability insurance analyst. **A life insurer shall not pay a life and disability insurance analyst any commission directly or indirectly, on any life or disability insurance transacted by and in the capacity as a life and disability insurance analyst.**

Anyone who acts or offers to act as a life analyst without a license is guilty of a misdemeanor and can be punished by a fine of up to \$1,000 or imprisonment for up to one year, or both imprisonment and fine.

DISTRIBUTIONS SYSTEM

Marketing is the method used by insurance companies to sell their products. Companies market their products by either using agents to sell their products or selling directly to the public through mass marketing.

An agent may be either an independent agent or an exclusive agent. An **independent agent** is a person who has an agency agreement with more than one insurance company. In such cases, the insurer does not train or finance the agent, but develops a relationship with a licensed agent to sell its products. The agent is responsible for financing his own agency. Such an arrangement gives the agent the ownership of the business he/she writes. Accordingly, the agent may place the insurance business with any company he/she represents and may transfer the insurance from one company to another if he/she deems it in the best interest of the client.

An **exclusive or captive agent** is a person who enters an agreement to represent one insurance company or a group of insurers that have a common ownership. Frequently an exclusive agent will be paid a training allowance for a period of time while being trained and getting established. An exclusive agent is compensated by commissions and renewal commissions after the first year. The insurer retains the ownership of the business and should the agent leave the company to work for another insurer, the book of business is given to another agent to service. Technically, exclusive agents are regarded as independent contractors paid commissions for the business written. The company provides a number of services for the exclusive agent. These services may include clerical support, preparing contracts, sending of renewal notices, and handling of claims.

The insurance code makes no distinction between an independent agent and an exclusive agent. The license issued gives both types of agents the same authority to transact insurance. The agency contract between the agent and the insurer determines whether the individual is either independent or exclusive.

A **general agent or managing general agent (MGA)** has a written contract with one or more admitted insurance companies. These contracts must be on file with the Commissioner. A managing general agent means any person, firm, association, partnership, or corporation who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer (including the management of a separate division, department or underwriting office) and acts as an agent for that insurer whether known as an MGA, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or

indirectly, and underwrites an amount of gross direct written premium equal to or more than 5 percent of the policyholder surplus as reported in the insurer's last annual statement and either: (1) adjusts or pays claims in excess of an amount determined by the commissioner, or (2) negotiates reinsurance of behalf of the insurer. (CIC 769.81c)

A managing general agent hires, trains, and supervises other agents. A MGA has the right to appoint as well as terminate local agents, the ability to bind coverage (only in the property and casualty field), collect premiums from producers and remit them to the insurers, and provide administrative support.

Under a **branch office system**, each sales office is managed by an agency manager who is an employee of the company and is usually compensated on a salary and bonus basis with the bonus relating to premium volume production of all the agents working in the branch office. Agency managers also are responsible for hiring and training agents.

OTHER DISTRIBUTION SYSTEMS

Although the majority of insurance is sold by agents, a large amount is provided to the public through mass marketing. This method is called a non-agency building system as agents do not market the products at the outset. Mass marketing is a cost effective method of distribution and may achieve efficient market penetration. Some of these methods are discussed below.

Direct response marketing is achieved by advertising through the mail, in newspapers and magazines, on television and radio and the internet. If someone is interested in the advertised products, he/she will respond to the company for more information.

Franchise marketing provides insurance coverage to employees of small firms and to members of associations. There is no master contract issued to the employer; rather each individual will receive a contract and needs to prove insurability. However, it allows for a lower premium than for insurance purchased on an individual basis. The premiums either may be paid entirely by the employer (non-contributory policy) or paid partially by the employee (contributory policy).

Non-insurance sponsors include credit card companies and banks. They target a select group of individuals who have a history of making periodic payments. Frequently, the sponsor is responsible for the billing, adding it to the billing statement or deducting it from the checking account.

Vending machine sales involve the use of coin-operated machines found in airports. The coverage is travel accident insurance and covers the purchaser for death or dismemberment during the duration of a single trip. A large amount of coverage is available for a low premium.

THE AGENCY RELATIONSHIP

An agency can be defined as a situation where one party (the agent) has the authority to act for another (the principal) in dealing with third parties. In other words, an agent acts on behalf of an insurance company when dealing with applicants and clients. Consequently, when a licensee is empowered to act as an agent for a principal, the agent legally is assumed to be the principal in matters covered by the grant of agency. If a client discloses important information to an agent, it is assumed to be the knowledge of the principal. If a client makes a payment to an agent, it is considered payment to the principal. Any contracts made by an agent are contracts of the principal.

A presumption of agency could exist if a principal were to supply a person with signs and evidence of authority. Thus, if an insurance company were to give an unlicensed person its forms and literature, it would appear that this person represented the insurer. The insurer could then be bound by the actions of this person whether or not the person had been given such authority.

The authority of the agent is one of three types. It is **express authority**, **implied authority**, or **apparent authority**. Although it might appear that only those acts for which an agent actually is authorized could bind the insurer, in truth, the agent's authority is quite broad and the insurer may be held responsible for the unauthorized acts of its representative.

Express authority is the actual authority a principal grants the agent. This authority is spelled out in the agent's written contract with the principal. Such authority includes the right of the agent to solicit applications for insurance on behalf of the principal. If an agent does not operate within the bounds of this agreement, it is possible that the agent may place himself/herself in a position of personal liability.

Implied authority is not spelled out in writing, but it is the authority the agent is assumed to have in order to carry out the intent of the written contract. Not every single act that the agent has the right to perform can be placed in the written contract. For instance, the contract might not state that an agent may collect a premium at the time of application for a life insurance policy. However, this is a normal and desirable business practice and it is assumed the agent does possess this right.

Apparent authority is a situation in which the agent's conduct causes a client or prospective insured to believe that the agent has the authority to sell an insurance policy and contract on behalf of the principal. If an agent were to continue to use insurance company documents, such as its application forms, rate manual, literature, and emblems on the door, the client reasonably may believe that the agent continues to represent the principal. It may be that the

principal has withdrawn the agent's action notice of appointment and the agent no longer represents the insurer.

FIDUCIARY RESPONSIBILITY (CIC 1733-1735)

A **fiduciary** is a person in a position of financial trust. Because a fiduciary is in this position of trust and confidence, the law demands a higher standard of conduct than it does of others in their business pursuits. Some people that are regarded as fiduciaries include attorneys, bank trust officers, CPAs, and insurance agents. Agents owe a fiduciary responsibility to applicants, clients, and insurers that they represent. Acting as a fiduciary requires the agent to:

- have a good business reputation
- be honest and trustworthy
- be fit and proper
- act in good faith
- be qualified to perform insurance business (hold necessary licenses)
- have knowledge of state laws and regulations and abide by them

A fiduciary must follow the following when handling the funds of others:

1. All funds received by a person who holds any kind of insurance license as agent, broker, or solicitor are received and held by that person in a fiduciary capacity (position of trust). Anyone who diverts or appropriates fiduciary funds for his/her own use is guilty of theft, which is punishable under criminal law.

Premiums advanced by a premium financier under terms of a finance agreement are fiduciary funds only if they are received by a person who holds a license.

2. A licensed person who receives fiduciary funds (a) must remit premiums, minus commissions, and any return premiums received or held by him/her to the insurer or entity entitled to get them or (b) must maintain the fiduciary funds on California business in a trustee bank account or depository in California separate from any other account, in an amount at least equal to the premiums and return premiums, less commissions, received by him/her which have not yet been paid to the persons entitled to them.

The person may commingle additional funds with fiduciary funds as he/she may deem prudent for the purpose of advancing premiums, establishing reserves to pay return commissions, or contingencies as may arise in his/her business of receiving and transmitting premium or return premiums.

3. Fiduciary funds which have not yet been remitted and which are not held in a trust account can be invested in the following instruments:
 - U.S. government bonds and treasury certificates or other obligations backed by the federal government.
 - Certificates of deposit of banks and savings and loan associations licensed by the federal government or any state government.
 - Repurchase agreements collateralized by U.S. government securities.
4. As a condition to maintaining the funds in one of the investment accounts, a written agreement must be obtained from each and every insurer or person entitled to the funds authorizing the maintenance and retention of earnings which accrue on the funds.
5. Evidence of the funds must be maintained on California business by a bank or savings and loan association in a trust account separate from any other account or depository in an amount at least equal to the premiums and return premiums, minus commissions, which have not yet been paid to the insurer or entity entitled to them. The commissioner shall not have jurisdiction over any disputes arising between parties concerning the maintenance of fiduciary funds.
6. A managing general agent must comply with all regulations concerning deposit, maintenance, and remittance of fiduciary funds. A managing general agent is a licensed property and casualty broker/agent or life-only and/or accident and health agent who has a written contract with one or more admitted insurers to manage the production of its business in a designated territory in California. A managing general agent:
 - Hires, supervises, and fire agents.
 - Accepts or declines risks.
 - Collects premiums from producing broker/agents and remits them to insurers under an account current system.
7. A property and casualty broker/agent, personal lines broker/agent, or surplus lines broker can deduct any return premiums due an insured from unpaid premiums the insured owes on the same or any other policy. An insurer may pay return premiums to a fire and casualty broker/agent for this purpose.

ADMINISTRATOR: (CIC 1759) A "third party" administrator is a person who collects premiums from and who settles or adjusts claims on behalf of employers in connection with life or health insurance coverage or annuities.

RESPONSIBILITIES OF PARTIES IN INSURANCE

As an agent represents the insurer, he/she has many responsibilities to the insurer. The responsibilities of the agent to the insurance company include:

- a fiduciary duty to the insurer
- conducting himself/herself with the degree of care of a prudent person
- remitting all money received to the principal
- disclosing all pertinent information to the insurer, particularly with regard to underwriting and risk selection
- making sure the application is accurately completed
- delivering the policy and collecting any premium due
- keeping informed and obeying all insurance laws and regulations

Although the agent does not technically represent the applicant/client, there are a number of responsibilities involved. These include:

- place the customer's interest first
- know your job and continue to increase your level of competence
- identify the customer's needs and recommend products and services that meet those needs
- accurately and truthfully represent products and services
- use simple language; talk the layman's language when possible
- stay in touch with customers and conduct periodic coverage reviews
- protect your confidential relationship with your client
- keep informed of and obey all insurance laws and regulations
- provide exemplary service to your clients
- avoid unfair or inaccurate remarks about the competition

The insurer also has responsibilities to the agent. These include:

- permitting the agent to act in accordance with the terms of the agent's contract
- recognizing all the provisions of the contract
- paying the agent compensation as outlined in the contract, reimbursing for all proper expenditures, and indemnifying for all damages suffered without fault on the part of the agent but occurring on account of the agency relationship
- keeping the agent informed of all new products and marketing methods

LIFE AND DISABILITY INSURANCE RECORDS: (CIC 10508-10508.5)

Insurers which transact life and/or disability insurance in California must maintain certain records pertaining to the activities of its agent which the commissioner may inspect or examine. The records must be delivered to the commissioner within 30 days following a written demand for them. The records

must be maintained for at least 5 years after the policy is delivered, or at least 5 years after the application is received if no policy was issued. The records may be originals, facsimiles, microfilm or electronic data processing printouts, and must include the names, dates, amounts and policy numbers involved, and:

1. The original application for each policy sold in California.
2. Premiums received for each policy issued.
3. Records showing all policies sold by every agent for each of the preceding five years.
4. The commissions paid for each insurance policy issued and to whom they were paid.
5. Records which identify any agent other than the one appearing on the application who handled any part of the insurance transaction for which there was no compensation.
6. Correspondence or written proposals sent to or received from a prospect, applicant, or insured by the insurer.
7. Correspondence or written proposals sent to or received from a policyholder about the election of nonforfeiture values or termination or non-renewal of a policy.
8. A written comparison of policy benefits, limitations, exclusions, or costs of existing accident, sickness, or long-term care insurance with proposed coverage.
9. A copy of the outline of coverage or disclosure statement required by law or regulation.
10. A copy of any correspondence between the policyholder and the agent or insurer.
11. Copies of correspondence between anyone acting on behalf of a policyholder or prospect and the agent or insurer.

It shall be the obligation of each life-only agent and/or accident and health agent and any other agent and insurer to preserve and maintain all applicable records defined in this section in his/her possession, in addition to those records transmitted to the insurer, at his/her principal place of business for a minimum of five years. The records shall be kept in an orderly manner so that the information therein is readily available, and any record shall be open to inspection or examination by the commissioner at all times.

CONTINUING EDUCATION

Licensees are subject to continuing education requirements. A life-only and/or accident and health agent, a property/casualty broker-agent, and a personal lines broker-agent are required to complete 24 hours of continuing education per two-year license term with 3 of these hours being on ethics. An agent who holds both a life-only and/or accident and health license and a property/casualty license needs only to complete 24 hours of continuing education per license term and may take subjects relating to any insurance license held. A license year upon initial licensing starts on the date the license is

issued. After that, each license year starts the first day of the month following the month in which the initial license was issued. A license year ends the following calendar year on the last calendar day of the month in which the initial license was issued. A license term is for two years. (CIC 1749.3(b), 1749.33(a))

Failing to complete the continuing education requirements results in termination of license. In order to reactivate the license, the individual must complete the necessary continuing education requirements, pay late penalties and fees, and reinstate all appointments and endorsements. (CIC 1749.8)

Accident and health licensees selling long-term care must complete eight hours of long-term care education every year for the first four years and thereafter eight hours of LTC education prior to each license renewal. These courses shall consist of topics related to long-term care services and long-term care insurance, including, but not limited to, California regulations and requirements, available long-term care services and facilities, changes or improvements in services or facilities, and alternatives to the purchase of private long-term care insurance. (CIC 10234.93) Agents who sell California Partnership must meet long-term care requirements plus eight hours every two years of California Partnership education. These hours of long-term care and partnership continuing education count toward the required continuing education hours needed by licensees and do not increase the hours of continuing education required..

A life licensee who wishes to sell annuities must complete 8 hours of continuing education on annuities prior to selling an annuity. Subsequent renewals will require 4 hours of continuing education on annuities. (CIC 1749.8) The additional hours of training on annuities count toward the needed 24 hours of continuing education per license period.

POLICY RETENTION

Retention of policies is beneficial to all parties. An agent by maintaining contact with clients can make sure the insurance coverage is appropriate and can make additional sales and provide the needed protection for the client. This benefits the agent and the insurer financially. It normally takes three years for the insurance company to be able to recapture the costs of issuing a policy. Retention benefits the client as he/she has the appropriate insurance coverage.

ERRORS AND OMISSIONS INSURANCE

Insurance agents can be held legally liable for the consequences of any errors or omissions they have made while conducting their business. For this reason, insurance agents need to carry professional liability insurance which is called errors and omissions insurance (E&O). E&O insurance provides coverage for an act, error, or omission the agent makes in rendering or failing to render professional services in the conduct of the his/her insurance profession. For

instance, an agent could be exposed to a law suit if a client claims that inadequate or improper coverage was recommended and that consequently the client suffered a loss. If a case goes to court, the E&O policy will cover the insured's legal defense costs even if the charge was frivolous. If the insured is found liable or settles out of court, the insurer pays the award amount up to the policy's coverage limit.

E&O insurance does not offer protection from intentional acts, criminal acts, liability assumed under contract, or bodily and personal injury. Apart from this, E&O policies have few exclusions. Although there is no standard E&O policy, there are certain characteristics that they do have. These policies normally have high deductibles—usually \$1,000 or more. Coverage normally is written on a limit per claim basis, but aggregate limits for all claims during the policy period are available. Limits of coverage commonly range from \$100,000 to several million dollars.

Most professional liability policies are written on a claims-made basis. This means insurers only cover claims made while the policy is in force for incidents that occurred during the policy period. The result is that if an error happened in March and the policy was cancelled in June and then a law suit was filed for that error in December, the policy would not cover the claim as the claim arose after the policy was no longer in force. Some policies are written on an occurrence basis which means the insurer will cover claims made after the policy period as long as the error happened while the policy was in force. Occurrence basis policies are rare and more expensive.

California Insurance Code

The following text is based on the California Insurance Code (CIC) and relates to some of the topics covered in this chapter. In order to fulfill the Department of Insurance requirements, some of this material is repeated in other sections of the course, especially in the Code and Ethics portion.

California Insurance Law: The Insurance Commissioner is elected by the people to serve a four-year term in the same general election in which the governor is elected. If a vacancy should occur during the term of the office, the governor shall appoint a replacement subject to approval by the legislature. (CIC 12900) The commissioner shall perform all duties imposed upon him by provisions of the insurance code and other laws regulating the business of insurance in this State, and he shall enforce the execution of such provisions and laws. (CIC 12921)

The California Code of Regulations (CCR) is made up of rules issued by the commissioner. The regulations may be changed or withdrawn by the commissioner. The CCRs are needed in order to administer the code. Although

the commissioner does not write the code, he is responsible for enforcing the code. Even though the CCRs are not law, they carry the same weight as law. A person who violates a regulation is subject to the same penalty as someone who violates the code.

An insurance professional should have knowledge of the California Insurance Code and the Code of Regulations. These documents identify many unethical and illegal practices. However, they are **not a complete guide to ethical behavior**.

Free insurance: No insurer shall participate in any plan to offer or effect any kind or kinds of insurance or annuities in this state as an inducement to the purchase or rental by the public of any property, real or personal or mixed, or services, without a separate charge to the insured for such insurance, nor shall any agent, broker, or solicitor arrange the sale of any such insurance. (CIC 777.1) This article does not apply to insurance offered as a guarantee of the performance of goods which is insurance to protect the purchasers of such goods nor does it apply to any title insurance or life or disability insurance written to pay off the balance of a debt in the event of the death or disability of the insured.

If any insurer, agent, broker, or solicitor willfully violates this provision regarding free insurance, the commissioner may suspend or revoke the certificate or license or other authority to do business or engage in an insurance occupation for a period not exceeding one year.

Insurance in connection with sales and loans; No person engaged in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property and no trustee, director, officer, agent or other employee, or affiliate of, any such person shall require, as a condition precedent to financing the purchase of such property or to loaning money upon the security thereof that the person for whom such purchase is to be financed or to whom the money is to be loaned negotiate any insurance covering such property through a particular insurance agent or broker. **(CIC770)**

Transacting without a license: (CIC 1631;1633) A person may not conduct any activities of an agent, broker, or solicitor unless he has a license issued by the commissioner authorizing him to act in that capacity. Anyone who acts, offers to act, or assumes to act in a capacity for which a license is required, without holding a license, is guilty of a misdemeanor. This is punishable by a fine not exceeding \$50,000 or by imprisonment in a county jail for a period not exceeding one year, or by both fine and imprisonment.

Title 18 United State Code Sections 1033-1034: According to Section 1033 it is a criminal offense for an individual who has been convicted of a felony involving dishonesty or breach of trust to willfully engage or participate in the business of insurance unless that person has first obtained the written consent of

the appropriate regulatory official. Furthermore, it is a criminal offense for any person to willfully employ or willfully permit such prohibited persons to participate in the business of insurance without the required written consent. In both of these cases, the individual can be fined as provided by this title or imprisoned not more than five years, or both.

Crimes include (1) knowingly with the intent to deceive make any false material statement or report or willfully and materially overvalue any land, property or security; (2) trying to influence any regulatory examiner in connection with any financial reports or documents required to be presented; (3) in conducting insurance business, willfully embezzle, abstract, purloin, or misappropriate any moneys, funds, premiums, credits, or other property; (4) jeopardize the safety and soundness of an insurer and cause the insurer being placed in conservation, rehabilitation or liquidation; (5) knowingly make any false entry of material fact in any book, report, or statement with intent to deceive; and (6) employ threats or force that corruptly influences, obstructs, or impedes the proper administration of the law involving the business of insurance whose activities affect interstate commerce.

The punishment for violation of this title is a fine as established under this title or imprisonment for not more than 10 years, except if the act jeopardizes the soundness of an insurer, the imprisonment shall not be more than 15 years. In #3, if the embezzlement or misappropriation does not exceed \$5,000, the violator can be fined as provided in this title or imprisoned not more than one year or both.

The California Department of Insurance has jurisdiction under this act to consider requests for written consent filed by prohibited persons who propose to participate in the business of insurance in California with a domestic insurer or a resident licensee. Such prohibited persons who propose to engage in the business of insurance in California shall:

- ❑ File a 1033 consent waiver application
- ❑ Pay the application fee
- ❑ Provide all required documentation
- ❑ Receive written consent before engaging in such business

Insurer transacting without a license: An insurer shall not transact any class of insurance business in California without first being admitted. The certificate will not be granted until the applicant conforms to the requirements of the code and of the laws of this state. The unlawful transaction of insurance business in willful violation of the requirement for a certificate of authority is a public offense punishable by imprisonment not exceeding one year, or by fine not exceeding one hundred thousand dollars (\$100,000), or by both fine and imprisonment. (CIC 700 (a), (b))

Aiding non-admitted insurer to transact: Except when performed by a surplus line broker, the following acts are misdemeanors when done in this State:

Acting as agent for a non-admitted insurer in the transaction of insurance business in this State.

In any manner advertising a non-admitted insurer in this State.

In any other manner aiding a non-admitted insurer to transact insurance business in this State.

In addition to any penalty provided for commission of a misdemeanor, a person violating the above shall forfeit to this state the sum of five hundred dollars (\$500), together with one hundred dollars (\$100) for each month of fraction thereof during which the violation continues. (CIC 703)

Any person licensed by the commissioner who misrepresents to any surplus lines broker any material fact regarding insurance coverage, or facts regarding rules of submission or rates, or conspires to procure non-admitted insurance in violation of the law, may have his license suspended, revoked, or denied.

Surplus Lines Law: (CIC 1760- 1780) Any person may negotiate and effect insurance to protect himself, herself, or itself against loss, damage, or liability with any non-admitted insurer.

The rules limiting the insurance which may be placed with non-admitted insurers do not apply to:

- (1) Reinsurance of the liability of an admitted insurer.
- (2) Insurance against perils of navigation, transit or transportation upon hulls, freights or disbursements, or other shipowner interests; upon goods, wares, merchandise and all other personal property and interests therein, in course of exportation from or importation into any country, or transportation coastwise, including transportation by land or water from point of origin to final destination and including war risks; and marine builder's risks, drydocks and marine railways, including insurance of ship repairer's liability, and protection and indemnity insurance, but excluding insurance covering bridges and tunnels.
- (3) Aircraft insurance.
- (4) Insurance on property or operations of railroads engaged in interstate commerce.

The insurance specified in the above numbers 2, 3, and 4 may be placed with a non-admitted insurer only by and through a special lines' surplus lines broker.

A surplus line broker may solicit and place insurance with non-admitted insurers only if that insurance cannot be procured from insurers admitted for the

particular class or classes of insurance and that actually write the particular type of insurance in this state. Each surplus line broker shall be responsible to ensure that a diligent search is made among admitted insurers before placing insurance with a non-admitted insurer. It shall be presumed that insurance is placed in violation of the code if the insurance is actually placed with a non-admitted insurer at a lower rate of premium or lower premium than the lowest rate of premium or the lowest premium that could be obtained from an admitted insurer unless, at the time the insurance attaches, there is filed with the commissioner a statement describing the insurance, specifying the rate and the nearest procurable rates from admitted insurers. The statement shall include an explanation of the reasons that the insurance must be placed with a non-admitted insurer even though it is available from an admitted insurer.

Every non-admitted insurer, in the case of insurance to be purchased by a resident of this state, and surplus line broker, in the case of any insurance with a non-admitted carrier to be transacted by the surplus line broker, shall be responsible to ensure that, at the time of accepting an application for any insurance policy, other than a renewal of that policy, issued by a non-admitted insurer, the signature of the applicant be on the disclosure statement. The disclosure statement shall be in boldface 16-point type on a freestanding document. In addition, every policy issued by a non-admitted insurer and every certificate evidencing the placement of insurance shall contain, or have affixed to it by the insurer or surplus line broker, the disclosure statement in boldface 16-point type on the front page of the policy. In the case where the applicant has not received and completed the signed disclosure form, he/she may cancel the insurance so placed.

The following notice shall be provided to policyholders and applicants for insurance with a non-admitted insurer and shall be printed in English and in the language principally used by the surplus line broker and non-admitted insurer to advertise, solicit, or negotiate the sale and purchase of surplus line insurance. The surplus line broker and non-admitted insurer shall use the appropriate bracketed language for application and issued policy disclosures:

“NOTICE:

- 1. THE INSURANCE POLICY THAT YOU (HAVE PURCHASED) (ARE APPLYING TO PURCHASE) IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NON-ADMITTED” OR “SURPLUS LINE” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT WHICH APPLIES TO CALIFORNIA LICENSED INSURERS.**

3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIM OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.
4. THE INSURER SHOULD BE LICENSED EITHER AS A FOREIGN INSURER IN ANOTHER STATE IN THE UNITED STATES OR AS A NON-UNITED STATES (ALIEN) INSURER. YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER _____. ASK WHETHER OR NOT THE INSURER IS LICENSED AS A FOREIGN OR NON-UNITED STATES (ALIEN) INSURER AND FOR ADDITIONAL INFORMATION ABOUT THE INSURER. YOU MAY ALSO CONTACT THE NAIC’S INTERNET WEB SITE AT WWW.NAIC.ORG.
5. FOREIGN INSURERS SHOULD BE LICENSED BY A STATE IN THE UNITED STATES AND YOU MAY CONTACT THAT STATE’S DEPARTMENT OF INSURANCE TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.
6. FOR NON-UNITED STATES (ALIEN) INSURERS, THE INSURER SHOULD BE LICENSED BY A COUNTRY OUTSIDE OF THE UNITED STATES AND SHOULD BE ON THE NAIC’S INTERNATIONAL INSURERS DEPARTMENT (11D) LISTING OF APPROVED NONADMITTED NON-UNITED STATES INSURERS. ASK YOU AGENT, BROKER, OR “SURPLUS LINE” BROKER TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.
7. CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARMTNET OF INSURANCE:
WWW.INSURANCE.CA.GOV.
8. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER’S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.

The list of eligible surplus lines insurers maintained by the California Department of Insurance is known as the LESLI List (List of Eligible Surplus Lines Insurers).

Appointment: A life-only agent, an accident and health agent, a property agent, a casualty agent, or a personal lines agent to act as an insurance agent shall have filed on his behalf with the commissioner a notice of appointment to act as an agent executed by an admitted insurer. Additional notices of appointment may be filed by other insurers before the license is issued and thereafter. (CIC 1704) Every property/casualty or personal lines solicitor applicant shall have filed on his behalf a notice executed by a property/casualty or personal lines broker/agent agreeing to employ the applicant. To act as a property/casualty broker or personal lines broker, a \$10,000 bond must be filed with the Department of Insurance.

An agent's appointment by an insurer serves as notice to the commissioner that the insurer has deemed the applicant to be a person of good reputation and character and is worthy to hold an insurance license.(CIC 1705) Appointments are effective as of the date the notice of appointment is signed by the insurer and continues in force until (1) the cancellation or expiration of the license applied for or held at the time the appointment was filed or (2) one of the parties (licensee or insurer) files a notice of termination.(CIC 1673) When all the appointments of a licensed life-only agent, accident and health agent, property/casualty agent, personal lines agent, or solicitor are terminated, the license becomes **inactive**. If a property/casualty or personal lines broker's bond is cancelled, his license becomes inactive. The license may be reactivated any time before it expires by filing a new appointment or broker's bond. An inactive license shall not permit its holder to transact any insurance for which a valid, active license is required. (CIC 1704(b))

Certificate of convenience: Upon the filing of an application for a license, the commissioner may make such investigation and require the filing of such supplementary documents, affidavits and statements as may be necessary to obtain a full disclosure of such information as will aid him in determining whether the prerequisites for the license have been met. If the applicant makes a showing satisfactory to the commissioner that he/she meets all such prerequisites, the commissioner may issue a certificate of convenience and, upon the applicant meeting any applicable examination requirements, may issue a permanent license. (CIC 1666)

Causes for denial after a hearing: The commissioner may deny a license, after a notice and hearing into the issue, for any of the following reasons: (CIC 1668)

- a. The applicant is not properly qualified to perform the duties of a person to hold the license for which applied.
- b. Granting the license would not be in the public interest.
- c. The applicant does not intend actively and in good faith to conduct business with the general public which would be permitted under the license for which applied.
- d. The applicant is not of good business reputation.
- e. The applicant lacks integrity.
- f. The applicant has been refused a professional, occupational, or vocational license, or has had such a license suspended or revoked for a reason that should preclude the granting of an insurance license.
- g. The applicant is seeking the license to avoid or prevent the operation or enforcement of the state's insurance laws.
- h. The applicant has knowingly or willfully made a misstatement in the license application or in a document filed to support the application, or has made a false statement to the commissioner in testimony given under oath.
- i. The applicant has previously engaged in a fraudulent practice or act or has conducted a business in a dishonest manner.
- j. The applicant has shown that he/she has been incompetent or untrustworthy in the conduct of a business, or has exposed the public or those dealing with him to the danger of loss, by committing a wrongful act or practice in the course of business.
- k. The applicant has knowingly misrepresented the terms or effect of an insurance policy or contract.
- l. The applicant has failed to perform a duty expressly required by the insurance code or has committed an act expressly forbidden by the code.
- m. The applicant has been convicted of a felony, a misdemeanor in violation of any insurance laws, or a public offense that involved fraud or dishonesty involving money or property.
- n. The applicant has aided or abetted another person in an act or omission for which that person's license could be suspended, revoked, or refused.
- o. The applicant has allowed any person employed by him to violate any provision of the insurance code.
- p. The applicant has violated any law relating to conduct of a business which could lawfully be done only by authority conferred by such license.

A judgment, plea or verdict of guilty or a conviction following a plea of *nolo contendere* is considered to be the same as a conviction.

Denial of license application without a hearing: The commissioner may deny an application for a license without conducting a hearing for any of the following reasons: (CIC 1669)

- a. The applicant has been convicted of a felony.

- b. The applicant has been convicted of a misdemeanor denounced by any insurance law.
- c. The applicant has had a previous application denied for cause within the last five (5) years.
- d. The applicant has had a license suspended or revoked for cause within the last five (5) years.

License revocation or suspension: The commissioner may suspend or revoke a permanent license for any of the same grounds for which a license application may be denied. As noted above, some grounds require a hearing while others do not. (CIC 1738)

Termination of license: (CIC 1708-1714)

1. A licensee may voluntarily surrender his license for cancellation at any time by delivering the license to the commissioner. If the license is in the possession of the insurer or the licensee's employer, the license may be surrendered by providing written notice to the commissioner of the licensee's desire to cancel.
2. All licenses issued to a natural person terminate when the person dies.
3. An organization ceases to exist as an entity eligible to hold a license upon the following:
 - a. A co-partnership dissolves or there is a change in membership.
 - b. An association terminates.
 - c. A corporation is dissolved.
4. A co-partnership may continue to transact business under its license if:
 - a. The surviving partnership files an application within 30 days registering the change in membership, pays the required fee, and furnishes the required bond (if acting as a broker).
 - b. At least one partner from the predecessor partnership continues to exercise the powers of agency or brokership with the new partnership.
 - c. The application is signed by a general partner.

Note: To return the old license to the commissioner with signatures of the original members is not a requirement.
5. When a licensed entity terminates, its right to transact insurance also terminates. However, a natural person, partnership, association, or corporation may continue to operate under an existing license as a different organization if:
 - a. A natural person is named to exercise the agency or brokerage powers.
 - b. There has been no substantial change in ownership or control of the licensed insurance business.
 - c. Within 30 days after the change, the person or successor partnership, association or corporation files a license application and pays necessary fees.

6. The license of an organization licensed as a life-only agent, accident and health agent, property and casualty broker/agent, or personal lines broker/agent becomes inoperative when the last natural person named on the license is removed or is no longer eligible to be licensed. The license will not be reactivated unless all deficiencies are corrected, including the addition of a natural person to transact insurance under the organization's license.

License renewal: (CIC 1720) An application on a form prescribed by the commissioner for the renewal of a license filed on or before the last day of the period for which the previous license was issued, accompanied by the renewal fee and satisfactory completion of all required continuing education, shall entitle the applicant to continue operating under the existing license for 60 days after its specified expiration date or until notified by the department of insurance that the renewal application is deficient.

An applicant or licensee shall notify the commissioner when any of the background information has changed after the application has been submitted or the license has been issued. If the licensee is listed as an endorsee on any business entity license, the licensee must also provide this notice to any officer, director, or partner listed on that business entity license. Background information means any of the following: a misdemeanor or felony conviction; a filing of felony criminal charges in state or federal court; an administrative action regarding a professional or occupational license; any licensee's discharge or attempt to discharge, in a personal or organizational bankruptcy proceeding, an obligation regarding any insurance premiums or fiduciary funds owed to any company, including a premium finance company or managing general agent; and any admission, or judicial finding or determination, of fraud, misappropriation or conversion of funds, misrepresentation, or breach of fiduciary duty. **Notification to the commissioner shall be in writing and shall be sent within 30 days of the date the applicant or licensee learns of the change in background information. (CIC 1729.2)**

Change of address: (CIC 1729) Every licensee and applicant for a license must immediately notify the commissioner by electronic service of any change in his residence address, business address, or mailing address. This also is true of any email address. This is especially important as agents' license renewals are sent by email.

Agency names: (CIC 1724.5, 1729.5) Every individual and organization licensee and every applicant for such a license shall file with the commissioner in writing the true name of the individual or organization and also all fictitious names under which he conducts or intends to conduct his business and after licensing shall file with the commissioner any change in or discontinuance of such names. The commissioner may in writing disapprove the use of any true or fictitious

name (other than the bona fide natural name of an individual) by any licensee on any of the following grounds:

1. The name interferes with or is too similar to a name already filed and used by another licensee.
2. Using the name may mislead the public in any way.
3. The name states or implies that the licensee is an insurer, motor club, hospital service plan or that the licensee is entitled to engage in insurance activities not allowed under the license.
4. The name states or implies that the licensee is an underwriter. However, this does not prohibit a natural person from using a designation like Chartered Life Underwriter (CLU) or Charter Property and Casualty Underwriter (CPCU) or a trade association whose members are individually licensed from using a name that includes the word "underwriter" (e.g. National Association of Life Underwriters).
5. The licensee has filed and has not discontinued use of more than two names, including the true name. A licensee who has bought an insurance business may use two additional names used by the previous owner(s) in conducting the business.

A licensee may not continue to use a true or fictitious name after the commissioner has notified the licensee in writing to stop. If there are mitigating facts in connection with the use of a particular name, the commissioner may permit continued use of the name for a reasonable time if there are conditions imposed that adequately protect the public.

A fire and casualty broker/agent or life-only and/or accident and health agent who has a service contract with a corporation licensed under this code or who is a stockholder or member of any incorporated association or corporation organized under the Corporations Code for the purpose of providing services to fire and casualty broker/agents or life-only and/or accident and health agents may use the name of such a corporation or association on any stationery or advertisements and other written or printed matter used to identify the business of the fire and casualty broker/agent or life-only and/or accident and health agent provided that the name of the fire and casualty broker/agent or life-only and/or accident and health agent is clearly identified as bearing only that relationship to the corporation or association in one of the following ways:

- "Representing _____;"
- "A stockholder of _____:"
- "Placing business through _____:"
- "Using services of _____."

A person licensed in this state as an insurance agent or broker who advertises insurance on the internet and transacts insurance in this state shall identify all of the following information on the internet regardless of who maintains the presence on the internet: name as filed with the commissioner,

state of domicile and principal place of business, and license number. A person would be deemed to be transacting if providing an insurance premium quote, accepting an application for coverage, or communicating regarding terms of an agreement to provide insurance with a California resident. (CIC 1726)

Notice: Any notice required to be given to any person by any provision of the code may be given by mailing notice, postage prepaid, addressed to the person to be notified at his residence or principal place of business in California. The affidavit of the person who mails the notice, stating the facts of such mailing, is prima facie evidence that the notice was thus mailed. (CIC 38)

Any written notice relating to any insurance or risk may be provided by electronic transmission if each party has agreed to conduct the transmission by electronic means. The affidavit of the person who initiated the electronic transmission is prima facie evidence that the notice was transmitted. A valid electronic signature shall be sufficient for any provision of law requiring a written signature. The insurance company shall retain a copy of the confirmation and electronic signature, if required, with the policy information so that they are retrievable upon request by the Department of Insurance while the policy is in force and for five years thereafter. (CIC 38.5)

Printing license number on documents and advertisements: (CIC 1725.5) Every licensee shall prominently print his license number on business cards, written price quotations for insurance products, and printed advertisements for insurance products distributed exclusively in California. The license number must be printed in the same size type as any telephone number, address, or fax number. If the licensee maintains more than one organization license, one of the organization license numbers is adequate for compliance.

In the case of solicitors working as exclusive employees of a motor club, organizational license numbers shall be used. These requirements do not apply to general advertisements of motor clubs that simply list insurance products as one of several services offered by the motor club and do not provide any details regarding insurance products.

Any person in violation of this section is subject to a fine of \$200 for the first offense, \$500 for the second offense, and \$1,000 for the third and subsequent offenses. The penalty will not exceed \$1,000 for any one offense. Separate penalties will not be imposed upon each piece of printed material that does not conform to the requirements of this regulation. The money from these fines will be deposited into the Insurance Fund.

Unfair trade practices: (CIC 790-790.10) The insurance industry is subject to the laws of California which apply to all types of business, including, but not limited to, the Unruh Civil Rights Act, anti-trust, and unfair business practice laws. The purpose of the rules regarding unfair practices is to define and regulate trade

practices in the business of insurance that are considered to be unfair, deceptive, or misleading. These provisions apply to all types of insurers and to all producers engaged in the insurance business. No one may engage in any practice that is prohibited by law or that is considered to be an unfair method of competition or an unfair or deceptive trade practice in the business of insurance.

The article regarding unfair trade practices applies to reciprocal and interinsurance exchanges, Lloyds insurers, fraternal benefit societies, fraternal fire insurers, grants and annuities societies, insurers holding certificates of exemptions, motor clubs, nonprofit hospital associations, life agents, broker/agents, surplus line brokers and special lines surplus line brokers as well as all other persons engaged in the business of insurance.

The following are unfair trade practices:

- (a) Misrepresentation.** It is against the law to make, issue, or circulate any estimate, illustration, circular or statement which:

 - Misrepresents the benefits, terms, or advantages of an insurance policy.
 - Misrepresents the dividends to be paid on an insurance policy.
 - Misrepresents the dividends paid in the past on a policy or similar policies.
 - Misrepresents the financial condition of an insurer or the legal reserve system used by an insurer.
 - Uses a policy name that misrepresents the true nature of a policy or class of policies.
 - Makes a misrepresentation to a policyholder that induces that policyholder to lapse, forfeit, or surrender his policy.
- (b) Untrue or deceptive information about a person engaged in insurance.** It is an unfair practice to advertise or distribute information about the insurance business, an insurer, or any person engaged in the business of insurance which is untrue, deceptive, or misleading.
- (c) Boycott, coercion, intimidation.** It is unlawful to commit or conspire to commit an act of boycott, coercion, or intimidation which results in unreasonable restraint of, or monopoly in the business of insurance.
- (d) Filing false financial statement.** It is unlawful to knowingly file with any public official or to publish, circulate, or place before the public a false statement of an insurer's financial condition, with intent to deceive.
- (e) False entries.** It is against the law to knowingly make an entry or deliberately omit an entry of a material fact in a book, report, statement or record which an insurer is required to file with the insurance department or any other public agency with intent to deceive a public official or examiner.

- (f) Unfair discrimination.** It is prohibited to make or allow unfair discrimination between persons of the same class and life expectancy in the rates charged or the terms, conditions, benefits, or dividends of a life insurance policy or an annuity. Differences based on sex are permitted if they can be substantiated by mortality data and other statistical information.
- (g) Advertising membership in the state's Guarantee Association.** Although membership in the California Insurance Guarantee Association is required for all insurers which offer the kinds of insurance protected by the Association, a member insurer may not advertise directly or indirectly that it is an Association member or that it is insured against insolvency.
- (h) Unfair claims practices.** The following unfair claims practices are prohibited:
- 1) Misrepresenting to claimants any pertinent facts or policy provisions which relate to the coverage at issue.
 - 2) Failing to acknowledge and act reasonably promptly on communications relative to policy claims.
 - 3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims.
 - 4) Failing to affirm or deny coverage within a reasonable time after proof of loss statements have been completed and submitted.
 - 5) Failing to make prompt, fair, and equitable settlement of claims where the company's liability has become reasonably clear.
 - 6) Requiring claimants to sue to recover amounts due under a policy by offering substantially less than the amounts ultimately recovered in lawsuits brought by insureds, when insureds have made claims for amounts similar to those ultimately recovered.
 - 7) Trying to settle a claim for less than a reasonable person would expect to receive by referring to printed advertising material accompanying or made part of the application.
 - 8) Trying to settle a claim on the basis of an application which was altered without the knowledge and consent of the insured.
 - 9) After payment of a claim, failing to inform insureds or beneficiaries of the coverage under which payment was made, when such information has been requested by them.
 - 10) Telling an insured or claimant that the insurer will appeal any judgment in favor of the claimant or insured in order to get him to accept less than the amount awarded in arbitration.
 - 11) Delaying an investigation or settlement of a claim by requiring the insured, claimant, and/or physician to file a preliminary claim report, then making them file formal claim papers which contain substantially the same information.
 - 12) Failing to settle claims promptly where liability is clear under one section of the policy in order to influence settlement under another section of the policy.

- 13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy for denying a claim or offering a compromise settlement.
- 14) Directly advising a claimant not to obtain the services of an attorney.
- 15) Misleading a claimant about the applicable statute of limitations.
- 16) Delaying the payment of or providing hospital, medical, or surgical benefits for services rendered for AIDS for more than 60 days after the insurer has received a claim in order to investigate and determine if the claim was for a pre-existing condition. Time spent waiting for information from an attending physician or other health care provider is not counted in this 60-day period.

Any person who engages in any unfair method of competition or any unfair or deceptive act or practice is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars (\$5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars (\$10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act.

If any person violates a cease and desist order or an order of the court, after it has become final and while it remains in effect, the commissioner may call a hearing to determine whether such violation has occurred. If it is determined that a violation was committed, the commissioner may order the person to pay either (1) a fine up to \$5,000 if the violation is not found to be willful plus the amount of any outstanding penalty for violating the code or (2) a fine of up to \$55,000 if the violation is found to be willful plus the amount of any outstanding penalty for violating the code. For any subsequent violation of a cease and desist order, court order, or order to pay a penalty, the commissioner may, after a hearing, suspend or revoke the person's license or Certificate of Authority for a period of up to one year.

Only the commissioner may enforce the provisions of the Unfair Practices Act. The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in the state in order to determine whether such person has been or is engaged in any unfair method of competition. **If the commissioner believes that any person engaged in the business of insurance in this state is engaged in any method of competition or practice not defined in the code, he/she can may conduct hearings. If the person is found guilty, the penalty shall be imposed by and determined by the commissioner. (CIC 790.05;790.35)**

(i) Advertising insurance that the insurer will not sell. It is an unfair and deceptive act for an insurer to advertise insurance that it will not sell. This does not prevent an insurer from advertising a product which it is licensed to sell but is not available for sale if the advertising clearly states that the insurance is not available. An intentional violation of this provision carries a penalty of up to \$10,000. This section does not apply to an insurer which refuses to sell a policy on the basis of its underwriting guidelines. This section does not apply to advertisements by an insurer where the ads are broadcasted (e.g. TV, radio) and originate from outside the state.

Fraudulent claims: It is against the law for a person to knowingly:

- Present a false or fraudulent claim for payment of a loss.
- Present multiple claims for the same loss or injury, including claims to more than one insurer, with intent to defraud.
- Cause or participate in a vehicle collision or other vehicular accident.
- Present a false or fraudulent claim for a loss due to theft, destruction, damage, or conversion of a motor vehicle, motor vehicle part, or motor vehicle contents.
- Prepare, make or subscribe any writing to support a false or fraudulent claim.
- Assist, abet, solicit, or conspire with any person who knowingly commits any of these violations.
- Make a false or fraudulent claim for payment of a health care benefit.
- Submit a claim for a health care benefit which was not used by the claimant.
- Present multiple claims for payment of the same health care benefit with intent to defraud.
- Present for payment any undercharges for health care benefits on behalf of a claimant unless known overcharges for health care benefits for that claimant are presented for reconciliation at the same time. (CIC 1871.4)

A violator can be imprisoned for up to one year in county jail, or 2, 3, or 5 years in state prison and/or be fined up to \$150,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine. If the violator has a prior felony conviction for the same offense, there shall be an additional two year sentence for each previous conviction. Additional criminal charges also may be imposed.

An insurer's claim form must carry the statement: "For your protection, California law requires the following to appear on this form" (or similar wording) followed by "A person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison". (CIC 1871.2) The person may be found guilty of perjury.

The California legislature is aware that the business of insurance involves many transactions that have potential for abuse and illegal activities. Many law enforcement agencies at the state and local levels are responsible for investigating and prosecuting fraudulent activities. Every insurer admitted to do business in this state shall maintain a unit or division to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds (CIC 1875.20) Insurers and their agents shall have access to all relevant public records that are required to be open for inspection when they are investigating suspected fraudulent claims. (1871.1)

Fraudulent claims harm everyone as they add to an insurer's overall claims experience. This might skew the actuarial projections of the insurer. To make up for these losses, an insurer will need to increase premiums which is an expense that will be borne by all policyholders. (CIC 1871)

There is a Bureau of Fraudulent Claims within the Department of Insurance. It was created to enforce the provisions prohibiting fraudulent claims and to enforce related sections of the Penal Code. (CIC 1872) To help prevent fraud, there is the National Automobile Theft Bureau. Every insurer is required to report private passenger automobiles involved in theft and salvage total losses. (CIC 1874.6)

Before settling a claim involving vehicle theft, the insurer shall secure a claim form from the insured that includes a warning that false representations on the form subjects the insured to the penalty of perjury, a detailed description of the insured vehicle, the purchase location of the insured vehicle, purchase date and name of seller, a detailed statement of the circumstances surrounding the theft, and the insured's current driver's license number. The insured must sign the claim form in the presence of the insurance agent, broker, or adjuster, or other claims representative who must verify the insured's driver's license number, or submit a notarized claim form, and the claim form shall be signed under penalty of perjury. The insurer must retain for three years all settlement checks in settling an auto theft, the original claim form, and a legible copy of the police report. (1871.3)

The Arson Information Reporting System permits insurers, law enforcement agencies, fire investigative agencies, and district attorneys to deposit arson case information in a common database within the Department of Justice. The purpose of this database is to identify utilization patterns by individual claimants and methods of operation of individuals, groups, or businesses engaged in the commission of arson and to prevent the perpetration of insurance fraud by arson. (CIC 1875.8)

When an insurer knows or reasonably believes it knows the identity of a person whom it has reason to think committed a fraudulent act relating to a worker's compensation insurance claim and believes it has not been reported to

an authorized governmental agency, the insurer or its agent shall notify the local district attorney's office and the Bureau of Fraudulent Claims of the Department of Insurance. The insurer must state in its notice the basis of its knowledge or reasonable belief. (CIC 1877.3(b)(1))

The commissioner may license an organization as an insurance claims analysis bureau provided it meets the necessary requirements. The commissioner shall license an insurance claims analysis bureau by class of claims for the following classes of insurance:

- Automobile bodily injury
- Automobile physical damage
- Automobile theft
- Fire and allied lines property damage
- General liability bodily injury
- Disability
- Life
- Workers' compensation (CIC 1875.13)

An insurance claims analysis bureau shall perform the following functions:

- Collect and compile information and data from members or subscribers concerning insurance claims.
- Disseminate information to members or subscribers relating to insurance claims for the purpose of preventing and suppressing insurance fraud.
- Promote training and education to further insurer investigation, suppression, and prosecution of insurance fraud.
- Provide, without a fee or charge, to the commissioner, all California data and information contained in the records of the insurance claims analysis bureau in furtherance of the prevention and prosecution of insurance fraud. (CIC 1875.14)

Insurance Information and Privacy Protection Act (IPPA): (CIC 791-791.26)

The purpose of this article is to establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance-support organizations; to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; to establish a regulatory mechanism to enable persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy; to limit the disclosure of information collected in connection with insurance transactions; and to enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision.

Notice of information practices: An insurance company or agent must provide a notice of information practices to all applicants or policyholders (1) when the policy is delivered if the only information to be used is collected from the applicant, insured or public records or (2) at the time of application if personal information will be collected from any source other than the applicant, insured or public records.

The notice must be in writing and must state:

1. Whether personal information may be collected from persons other than the applicant proposed for coverage.
2. The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect the information.
3. The circumstances under which the disclosures may be made without prior authorization.
4. A description of the applicant's rights and the manner in which those rights may be exercised.
5. That information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons.

An acknowledgment that the company's information practices have been disclosed must be signed by the applicant and submitted with the application. Further, an insurance institution or agent must clearly specify questions on an application designed to obtain information solely for marketing or research purposes.

Disclosure authorizations are forms or statements with which a person authorizes personal or confidential information about him to be disclosed. This authorization must:

1. Be written in plain language.
2. Be dated.
3. Specify the types of persons authorized to disclose information (i.e. friends, neighbors, employer).
4. Specify the nature of the information authorized to be disclosed (habits, personal traits).
5. Name the insurance institution or agent to whom the individual authorizes information to be disclosed.
6. Specify the purposes for which the information is collected (e.g. to underwrite an application for insurance).
7. Specify the length of time for which the disclosure authorization is valid. The maximum length of time for life, health or disability insurance is 30 months and one year for property and casualty insurance.

8. Advise the individual that he is entitled to receive a copy of the authorization form.
9. This section shall not be construed to require any authorization for the receipt of personal or privileged information about an individual.

Corrections in reports may be requested by individuals. An individual may request that the information be corrected, amended, or deleted. The individual must provide the facts to support the request. Within 30 days of receiving the request, the insurance company, agent, or insurance support organization must (1) correct, amend or delete the portion of record information in dispute or (2) notify the individual that it will not make the alteration in the record, giving the reasons for that refusal and notify the individual of his right to file a statement.

Penalties: The commissioner has the right to examine and investigate every insurance organization or agent doing business in the state to determine if the privacy laws have been violated. If the commissioner has reason to believe that the law is being violated, he may serve notice and conduct a hearing into the allegation. An insurance support organization transacting business outside of the state, which has an effect on a person residing in California, is deemed to have appointed the commissioner to accept service of process on its behalf, provided that the commissioner sends a copy of the service by registered mail to the insurance support organization.

After a hearing, the commissioner must put his findings in writing and can issue a cease and desist order if he finds the law has been broken. If the person violates the cease and desist order, the commissioner can impose a fine of up to \$10,000 for each violation. If the violations occur with such frequency that they clearly are a general business practice, the fine can be up to \$50,000. If a company or agent knew or should have known that the rules were being violated, the commissioner also may suspend or revoke the company's certificate of authority or the agent's license.

Any person who knowingly and willfully obtains information about an individual from an insurance institution, agent, or insurance support organization under false pretenses can be fined up to \$10,000 or imprisoned for up to one year, or both.

Gramm-Leach-Bliley Act (GLBA): The Financial Modernization Act of 1999, know as the "Gramm-Leach-Bliley Act" or GLBA, has provisions to protect consumers' personal financial information held by financial institutions. There are three main parts to the privacy requirements. They are (1) the Financial Privacy Rule, (2) Safeguard Rule, and (3) pretexting provisions.

The Financial Privacy Rule governs the collection and disclosure of customers' personal financial information by financial institutions and other

companies who receive such information. Customers are entitled to receive a privacy notice every year. The notice must be given to the customers or consumers by mail or in person. The privacy notice must be a clear, conspicuous, and accurate statement of the company's privacy practices. It should include what information the company collects about its consumers or customers, with whom the information is shared, and how it safeguards the information. The notice applies to the "nonpublic personal information" the company gathers and discloses about its customers and consumers. Customers and consumers have the right to "opt out" of having their information shared with certain third parties. The **GLBA** does not give consumers the right to opt out when the financial institution shares other information with its affiliates.

The Safeguards Rule requires all financial institutions to design, implement, and maintain safeguards to protect customer information. This rule applies not only to financial institutions that collect information from their own customers, but it also applies to financial institutions such as credit reporting agencies that receive customer information from other financial institutions.

The pretexting provision prohibits the practice of obtaining customer information from financial institutions under false pretenses. A pretext interview is an interview whereby a person, in an effort to get confidential information about another person: (1) pretends to be someone he is not; (2) pretends to represent a person he is not in fact representing; (3) misrepresents the true purpose of the interview; or (4) refuses to identify himself upon request. Pretext interviews may not be used by anyone engaged in the business of insurance except when investigating claims where there is a reasonable basis for suspecting fraud, criminal activity, material misrepresentation or non-disclosure.

California Financial Information Privacy Act (California Financial Code Sections 4050-4060): The intent of this act is to afford greater privacy protections than those provided by the GLBA (Gramm-Leach-Bliley Act). It unites the federal GLBA with the Insurance Information Privacy and Protection Act (IPPA) contained in the insurance code. Enacted in 2003, the **act's** biggest impact is the required implementation of greater "opt-out/opt-in" choices with enhanced privacy requirements. The following is a comparison of the California law (Cal-GLBA) and the federal law (GLBA).

<u>Provision</u>	<u>Cal-GLBA</u>	<u>GLBA</u>
Selling or sharing information with outside company	Opt-In	Opt-Out
Selling or sharing with affiliates and subsidiaries	Opt-Out	No-Opt
Sharing between 2 financial institutions jointly offering a financial product	Opt-Out	No-Opt
Sharing to complete a transaction	No-Opt	No-Opt
Clear & readable consumer form?	Yes	No

Legend:
 Opt-In=Company must receive consumer permission first.
 Opt-Out=Consumers can stop sharing if they object.
 No-Opt=Consumers cannot stop the sharing

File and Record Documentation: (Title 10, CCR 2695.3)

Every licensee’s claim files shall be subject to examination by the commissioner. These files shall contain all documents, notes and work papers (including copies of all correspondence) that reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee’s actions pertaining to the claim can be determined.

To assist in such examination all insurers shall:

1. Maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of claim, date of acceptance, denial or date closed without payment. This data must be available for all open and closed files for the current year and the four preceding years.
2. Record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file.
3. Maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, non-existence of

data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual circumstances providing the licensee establishes to the satisfaction of the commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with these rules continue to exist.

Duties upon Receipt of Communications: (Title 10, CCR 2695.5)

Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than 21 calendar day of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts known by the licensee. The response is to address all inquiries made by the Department of Insurance and include copies of any documentation and claim files requested.

When a licensee receives any communication from a claimant where a response is expected, the licensee shall immediately, but in no event more than 15 calendar days, furnish the claimant with a complete response based on the facts known by the licensee.

The person authorized to represent the claimant shall be stated in writing and signed and dated by the claimant. A claimant may revoke such a designation by writing the insurer to this effect.

Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer. Upon receipt of notice of claim, every insurer shall immediately, but in no event more than 15 calendar days later, (1) acknowledge receipt of such notice of claim unless payment has already been made; (2) provide to the claimant necessary forms, instructions, and reasonable assistance; and (3) begin any necessary investigation of the claim. An insurer cannot require that the notice of claim be provided in writing unless such requirement is specified in the insurance policy or an endorsement. If the acknowledge is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated.

Standards for Prompt, Fair and Equitable Settlements: (Title 10, CCR 2695.7)

No insurer shall discriminate in its claims settlement practices based upon the claimant's age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured. (Title 10, CCR 2695.7(a) Upon receiving proof of claim every insurer shall immediately, but in no event more than 40 calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety. This time frame does not apply to disability insurance,

disability income insurance, mortgage guaranty insurance, or automobile repair bills arising from collision and comprehensive claims. (Title 10, CCR 2695.7(b))

When an insurer denies or rejects an insured's claim, in whole or in part, it must do so in writing and contain the bases for such rejection or denial. If a claimant believes that a claim has been wrongfully denied or rejected, he/she may have the matter reviewed by the California Department of Insurance and the insurer must inform the claimant of this fact as well as providing address and telephone of the unit of the Department that reviews claim practices.

If more time is required than the allotted 40 days to determine whether a claim should be accepted or denied, every insurer shall provide the claimant with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every 30 calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made. An insurer does have to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim. (Title 10, CCR 2695.7(c))

No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

1. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim.
2. The extent to which the insurer considered legal authority or evidence made known to it or reasonably available.
3. The extent to which the insurer considered the advice of its claims adjuster as to the amount of damages.
4. The extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits.
5. The procedures used by the insurer in determining the dollar amount of property damage.
6. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter.
7. Any other credible evidence presented to the commissioner that demonstrates that the final amount offered is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim. (Title 10, CCR 2695.7(g))

Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer shall immediately, but in no event more than 30 calendar days later, tender payment or otherwise take action to perform its claim obligation. In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than 30 calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. These time frames do not apply to disability insurance, disability income insurance, mortgage guaranty insurance, automobile repair bills arising from collision and comprehensive insurance, and title insurance. (Title 10, CCR 2695.7(h)) No insurer shall inform a claimant that his/her right may be lost if a form or release is not completed within a specified time period unless the information is given to advise the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the Department of Insurance regarding the handling of a claim as a condition to the settlement of any claim.

DISCRIMINATORY PRACTICES

Application or report carrying identification: (CIC 10141-10142) An application or investigative report furnished by an insurer to its agents or employees in the course of determining an applicant's insurability, cannot carry any identification as to the applicant's race, color, religion, national origin, or ancestry. If it is used only to identify the applicant and not as a basis for discrimination, the insurer may ask where an applicant was born.

Practices based on race or color: A licensed insurer may not refuse to accept an application, issue, or cancel insurance or charge a higher premium because of a person's race, color, religion, national origin, ancestry, or sexual orientation. In underwriting life and disability insurance, an insurer may not consider an applicant's sexual orientation or use marital status, living arrangements, occupation, gender, beneficiary designation, or zip codes to establish an applicant's sexual orientation or to decide if the applicant should be tested for HIV antibodies. The penalty for knowingly violating this provision can be a fine of \$1,000 up to \$5,000 plus court costs. (CIC 10140)

The insurance code requires strict confidentiality of personal information obtained through HIV testing and requires informed consent before any insurer tests for HIV. (CIC 799)

Genetic disability traits: (CIC 10143) An insurer may not refuse to issue, sell, or renew a life or disability policy solely because the person to be insured carries

a gene which may cause a disability in the insured's children but which causes no ill effects to the carrier. Examples include sickle cell, Tay-Sachs, and X-linked hemophilia. An insurer may not charge an applicant a higher premium (individual or group) due to a person to be insured having these traits.

An insurer may not insert a condition or stipulation in a policy that the insured person with such a trait, his/her heirs, or beneficiaries must accept less than the full value of the policy in event of a claim. An insurer may not pay a lower commission to an agent or broker for selling or renewing life or disability policies on persons possessing these traits.

Physically or mentally impaired: (CIC 10144) An insurer who issues individual or group life, annuity, or disability policies may not refuse to insure, continue to insure, limit the amount or kind of coverage available, or charge a higher premium for the same coverage to a physically or mentally impaired person except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual and reasonably anticipated experience.

Physical or mental impairment means any physical, sensory, or mental impairment that substantially limits one or more of that person's major life activities.

Blindness or partial blindness: (CIC 10145) An insurer who issues individual or group life, annuity, or disability policies may not refuse to insure, continue to insure, limit the amount or kind of coverage available, or charge a higher premium for the same coverage because an applicant is blind or partially blind.

SPECIAL CONCERNS—SENIOR CITIZENS (CIC 785-789.10)

All insurers and licensees owe a prospective insured who is 65 years of age or older, a duty of honesty, good faith, and fair dealing.

All brokers, agents, or other entities offering disability to persons 65 or older shall provide the prospective insured with a full and accurate written comparison with health coverage, and shall explain the relationship of the proposed coverage to any existing health benefits provided by Medicare, Medi-Cal, or any other health benefits available to the applicant. The commissioner may prescribe a standard comparison form and informational brochure to be distributed to every prospective insured at the time insurance is offered.

Any advertisement or other device designed to produce leads based on a response from a potential insured which is directed towards persons 65 or older shall prominently disclose that an agent may contract the applicant. No insurer, licensee, or other entity shall solicit seniors by using a true or fictitious name that is deceptive or misleading. Advertisements shall not use names or symbols that are similar to government agencies, non-profit or charitable institutions, or senior organizations as this could mislead the

public. No advertisement for an event where insurance products will be offered for sale may use the terms “seminar,” “class,” “informational meeting,” or other similar words unless it adds “and insurance sales presentation” in the same size and font.

All advertisements used by insurance licensees shall have written approval of the insurer before they may be used. Advertisements may not imply that members of a particular class will receive reduced rates when the insurance is in fact being sold on an individual basis.

An insurer or other licensee shall not knowingly sell disability insurance providing health benefits directly to a Medi-Cal beneficiary who is 65 or older. Nor shall an insurer or licensee replace a disability insurance policy or certificate unnecessarily or sell a disability policy that results in the insured having coverage for medical benefits for more than 100% of actual medical expenses. No insurer or licensee shall promote overloading. “Overloading” is the possession by an insured of functionally identical coverages that overlap or duplicate benefits. The application to sell disability insurance to seniors shall contain questions designed to discover if other health and disability coverage is in force.

Any licensee or other entity (other than an insurer) that violates these rules is liable for an administrative penalty of no less than one thousand dollars (\$1,000) for the first violation. For a second or subsequent violation the administrative penalty is no less than five thousand dollars (\$5,000) and nor more than fifty thousand dollars (\$50,000) for each violation. An insurer violating these rules is liable for an administrative penalty of ten thousand dollars (\$10,000) for a first violation. If an insurer violates these rules with a frequency as to indicate a general business practice, the administrative penalty is no less than thirty thousand dollars (\$30,000) and no more than three hundred thousand dollars (\$300,000) for each violation.

Insurance policies or certificates of disability insurance sold to persons age 65 or older shall return to policyholders or certificate holders benefits that have a minimum loss ratio of 60% for individual policies and 75% for group policies. The loss ratio shall be on the basis of incurred claims experience and earned premiums.

Sales of disability insurance as well as Medicare supplement insurance and long-term care insurance sold to persons aged 65 years or older, shall be registered by the insurer with the commissioner.

If a life agent offers to sell an elder (anyone 65 or older) any life insurance or annuity product, the life agent shall advise in writing that the liquidation of any assets to fund the purchase may have tax consequences and that

the elder or elder's agent may wish to consult independent legal or financial advice.

The following applies to the sale, offering for sale, or generation of leads for the sale of life insurance, including annuities, to senior insureds or prospective insureds by any person.

Any person who meets with a senior in the senior's home is required to deliver a notice in writing to the senior no less than 24 hours prior to that individual's initial meeting in the senior's home. If the senior has an existing insurance relationship with an agent and requests a meeting with the agent in the senior's home the same day, a notice shall be delivered to the senior prior to the meeting. The notice shall be in substantially the following form, with the appropriate information inserted, in 14-point type:

(1) During this visit or a follow-up visit, you will be given a sales presentation on the following (indicate all that apply):

____ Life insurance, including annuities

____ Other insurance products (specify):_____.

(2) You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

(3) You have the right to end the meeting at any time.

(4) You have the right to contact the Department of Insurance for information, or to file a complaint. (The notice shall include the consumer assistance telephone numbers at the department.)

(5) The following individuals will be coming to your home: (list all attendees, and insurance license information, if applicable)

Upon contacting the senior in the senior's home, the person shall, before making any statement other than a greeting, or asking the senior any other questions, state that the purpose of the contact is to talk about insurance, or to gather information for a follow-up visit to sell insurance, if that is the case, and state all of the following information:

____ The name and titles of all persons arriving at the senior's home.

____ The name of the insurer represented by the person, if known.

Each person attending a meeting with a senior shall provide the senior with a business card or other written identification stating the

person's name, business address, telephone number, and any insurance license number.

The persons attending a meeting with a senior shall end all discussions and leave the home of the senior immediately after being asked to leave by the senior.

A person may not solicit a sale or order for the sale of annuity or life insurance policy at the residence of a senior, in person or by telephone, by using any plan, scheme, or ruse that misrepresents the true status or mission of the contact.

REVIEW QUESTIONS

1. An admitted insurer is:

- A. Domiciled in the state of California.
- B. Domiciled in the state of California and authorized to transact.
- C. Organized under the laws of another state.
- D. Either domestic, foreign, or alien.

(page 4)

2. Which of the following is a correct statement about an admitted insurer?

- A. It must have its home office in this state.
- B. It is an insurer approved to do business in California but organized under the laws of another state.
- C. It is an insurer organized in California but not holding a certificate of authority to transact.
- D. Any insurer approved to transact business in California is an admitted one, without regard to location.

(page 4)

3. Who writes the insurance code?

- A. The insurance commissioner
- B. The governor of the state
- C. The state legislature
- D. None of the above.

(page 6)

4. What type of an insurance company issues participating policies?
- A. Reciprocal
 - B. Mutual
 - C. Stock
 - D. Fraternal
- (page 1)
5. What is the retention limit?
- A. The minimum amount a company is willing to retain on a risk.
 - B. The maximum amount a company is willing to retain on a risk.
 - C. It is a deductible required on a health policy.
 - D. It is the maximum amount an insurance company is allowed to write.
- (page 3)
6. A foreign insurer is:
- A. An insurer organized under the laws of any state except California and is not admitted.
 - B. An insurer organized outside of the United States and is not admitted.
 - C. An insurer organized in California and transacts outside the United States.
 - D. An insurer organized under the laws of any jurisdiction outside the State of California, whether or not admitted.
- (page 4)
7. An insurer admitted to do business in California may elect not to participate in a guarantee association.
- A. True
 - B. False
- (page 10)
8. An independent agent is:
- A. Someone who is appointed by only one insurer.
 - B. Someone who has appointments with several insurers but represents the client.
 - C. Someone who has appointments with non-admitted insurers.
 - D. Someone who has appointments with several insurers and represents the insurers.
- (page 17)

9. A managing general agent is a licensed insurance agent:
- A. Who has a management contract with one or more admitted insurers.
 - B. Who has the power to appoint, supervise, or terminate the appointment of local agents in a specified territory.
 - C. Who has the power to accept or decline risk.
 - D. All of the above.
- (page 17)
10. When an insurance company reinsures a risk, the ceding company relinquishes all responsibility for the payment of any potential loss.
- A. True
 - B. False
- (page 3)
11. Agents may possess three types of authority: express, implied and apparent. Which of the following is apparent authority?
- A. An agent acts within the guidelines of his/her written contract of agency.
 - B. An agent performs some duties needed to carry out his/her written contract. However, these acts are not specified in the contract of agency.
 - C. An agent uses the application forms and literature of an insurer with whom he no longer has an appointment.
 - D. All of the above.
- (page 19)
12. Vending machines at airports selling accidental death and dismemberment policies are an example of:
- A. Franchise marketing
 - B. Mass marketing
 - C. Group marketing
 - D. Agency marketing
- (page 18)

13. Which of the following describes a reciprocal?
- A. It is an incorporated association owned by the policyowners
 - B. It is an insurer that assesses all its members additional sums when a member has a claim.
 - C. It is an insurer that has a lodge, elected officers, and sells insurance to members.
 - D. It is an unincorporated association of subscribers who agree to insure one another.
- (page 2)

14. An insurance agent has a fiduciary duty to:
- A. The insurer
 - B. The applicant
 - C. The client
 - D. All of the above
- (page 20)

15. The insurance commissioner should complete an audit of each insurer doing business in California at least:
- A. Each year
 - B. Once every two years
 - C. Once every five years
 - D. When an insurer needs rehabilitation
- (page 7)

16. Who does a solicitor represent?
- A. An insurer
 - B. A life-only agent
 - C. A property and casualty agent/broker
 - D. A client
- (page 15)

17. What are the functions of an actuary?
- A. Prepare annual statements
 - B. Determine dividends
 - C. Determine premiums and make sure they are adequate
 - D. All of the above
- (page 13)

18. A life insurance agent must maintain records for a minimum period of:
- A. 3 years
 - B. 5 years
 - C. 10 years
 - D. 20 years
- (page 23)
19. A life agent's records must include all the following except:
- A. All correspondence between the agent and the policyholder.
 - B. Printed material in general use which has been distributed by the insurer.
 - C. A copy of the outline of coverage.
 - D. Records showing all policies sold by the agent.
- (page 23)
20. What describes an exclusive agent?
- A. One who transacts insurance for a number of companies.
 - B. One who owns the expirations of the policies.
 - C. One who transacts insurance only for the appointing company.
 - D. One who writes insurance for members of certain clubs.
- (page 17)
21. A person with an insurance agent/broker license is placing business with a company with whom he has an appointment. He is acting as:
- A. A broker.
 - B. An agent.
 - C. A solicitor.
 - D. He may choose to act as any of the above.
- (page 15)
22. Which of these is true about records kept by an insurance agent or broker?
- A. A licensee must allow the commissioner to inspect any record he has of an insurance transaction at any time.
 - B. A licensee must allow the commissioner to inspect only the records of an insurance transaction required to be kept by law at any time.
 - C. A licensee must allow the commissioner to inspect the required records of an insurance transaction only after prior notice and hearing.
 - D. A licensee must allow the commissioner to inspect the required records of an insurance transaction only after a search warrant has been served upon him to that effect.
- (page 23)

23. Which of the following best describes a mutual insurance company?
- A. A corporation owned by individuals who contribute capital through the purchase of stock.
 - B. A corporation owned by individuals who contribute capital through the purchases of policies.
 - C. An unincorporated society without capital stock which provides benefits to its members.
 - D. None of the above.
- (page 1)
24. All are true about the California Life and Health Insurance Guarantee Association except:
- A. The association may assess the member insurers for the necessary funds to run the association.
 - B. If an insurer does not pay the assessment when due, it may have its authority to transact suspended or revoked by the commissioner.
 - C. The association agrees to pay the entire amounts for which an impaired company is liable.
 - D. The association is to protect policyowners, insureds, and beneficiaries against loss when a member company becomes financially impaired.
- (pages 11-12)
25. When should a licensee notify the commissioner of a change of address?
(CIC 1729)
- A. The change of address should be made at the time of license renewal.
 - B. The code has no regulations regarding change of address.
 - C. Licensees must notify the commissioner immediately by electronic service of any change of address.
 - D. Licensees have 60 days to notify the commissioner in writing of a change of address.
- (page 34)

26. Which of the following is true when an applicant or licensee has any change of background information after an application has been submitted or a license has been issued? (CIC 1729.2 (d))

- A. Licensees need to notify the commissioner within 30 days. Applicants have no such requirement.
- B. The only change of background information that needs to be reported by an applicant or licensee involves being convicted of a felony.
- C. Licensees are not required to notify any business entity of a change of background information if he/she is endorsed on that license.
- D. The commissioner must be notified in writing by an applicant or licensee of any change in background information within 30 days.
(page 34)

27. According to code, it is permissible for a person engaged in the lending of money secured by real or personal property to require the borrower to use a specific agent or company for insurance coverage. (CIC770)

- A. True
- B. False
(page 26)