ETHICS FOR THE INSURANCE PRODUCER

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Before you begin, take a moment and ask yourself the question: What has happened to ethics in our society today? Recent scandals in the corporate, accounting, financial and insurance industries have badly damaged consumer confidence in all of corporate America and have brought unprecedented attention to business ethics and a need for a re-examination of what ethical practices really mean.

These new concerns have had a profound impact on the public confidence in corporate America and especially the insurance industry. For the insurance industry where consumer trust and confidence are paramount, honesty, integrity and an ethical corporate culture are even more critical. Consumers looking at the media coverage must have their doubts. News reports contain words like “scams,” “abuses,” “schemes,” and even fraud.

As an insurance producer, you come into ethical dilemmas almost daily. Maintaining ethics and integrity is in the best interest of every insurance producer. In recognition of the growing ethical dilemmas that insurance producers are facing, many state lawmakers have taken a proactive approach to make ethics a mandatory requirement for insurance producers in meeting their on-going continuing education requirements. This book has been designed to meet those state requirements as well as to help insurance producers identify possible ethical dilemmas and provide the tools to help resolve those issues.

The book includes:

- Six chapters with review questions at the end of each chapter
- Answers to the Final Course Review
- A Final Exam**

** To be used only if you plan to submit the exam for continuing education correspondence credit. For more information contact Broker Educational Sales and Training at 800-345-5669, or email at: customerservice@brokered.net
CHAPTER 1

INTRODUCTION

Overview

Today, an increasing amount of States now require insurance producers and brokers to be tested as part of their continuing education requirement in the area of ethics. The purpose of this is twofold. One, licensed professionals are held to a higher level of legal responsibility to the general public and more specifically to their clients. Two, by standardizing ethics practices the insurance producer (agent) will run into less risk of unethical practice suits by the general public.

In this chapter, we will define what ethics is and is not. It will also examine the importance of ethics in every-day life, and how to develop standards to assist us in making ethical decisions.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Define ethics;
- Demonstrate the importance of ethics;
- Determine what is not ethics;
- Distinguish between the five different ethical standards;
- Identifying the various methods for exploring ethical dilemmas and identifying ethical courses of action;
- Apply the Golden Rule in your day to day activities; and.
- Demonstrate the general ethical standards in which to live by and work by.

Ethics Defined

Ethics is the branch of study dealing with what is the proper course of action for man. It answers the question “What do I do?” It is the study of right or wrong in human endeavors. At a more fundamental level it is a method by which we categorize our values and pursue them.

The study of ethics can be traced back to the Greeks, who attempted to categorize fallible human behavior against divine ideals. In fact, Aristotle is considered the father of ethics. Our word ethics is derived from two Greek antecedents:
• “ethikos”, or correct social behavior; and
• “ethos”, or character.

Today, if you were to search for a definition of ethics in a dictionary you’ll find that ethics is defined as:

- **Ethics** (n.1) “The science of human duty’s; the body of rules of duty drawn from this science; a particular system of principles and rules concerning duty, whether true or false; rules of practice in respect to a single class of human actions; as political or social ethics; medical ethics.” (Webster (1913) Dictionary)
- **Ethics** (used with sing. verb or pl. verb): “The study of the general nature of morals and of the specific moral choice to be made by a person; moral philosophy. The rules of standards governing the conduct of a person or the members of a profession.” (American Heritage Dictionary)

According to the Josephson Institute ethics is defined as:

“Standards of Conduct that indicate how one should behave based on moral duties and values.”

So then, ethics refers to principles that define behavior as right, good and proper. Such principles do not always dictate a single “moral” course of action, but provide a means of evaluating and deciding among competing options. Ethics is not just what is imposed by law, not just what is defined in a company policy, not just what is written into a code. Ethics is more than what is expected by civilized society. Ethics rises above each and all, of those standards. Ethics is the choice to do what is right, not because it is required or expected but because it is RIGHT. That requires making sometimes hard decisions. But therein is ethics.

**Why is Ethics Important?**

Ethics is so important because it is a requirement for human life. It is the means of deciding a course of action. Without it, your actions, not just as an insurance producer but in everyday life, would be random and aimless. There would be no way to work towards a goal because there would be no way to pick between a limitless numbers of goals. Even with an ethical standard, we may be unable to pursue our goals with the possibility of success. To the degree which a rational ethical standard is taken we are able to correctly organize our goals and actions to accomplish our most important values. Any flaw in our ethics will reduce our ability to be successful in our endeavors.

Taking this course and other courses on ethics, hopefully, will help insurance producers make the right decision when they find themselves, as they often do, in ambiguous, confusing or otherwise difficult situations that present a conflict of interest or situations that may be perfectly legal but not necessarily ethical. Such situations are so common that many clients say ethical behavior is the number one characteristic they want in their
insurance producer. And strong ethical behavior is an invaluable characteristic to an insurance producer’s success. Ethical insurance producers immediately gain the trust, respect, and loyalty of their clients. Such clients provide additional business and valuable referrals.

Ethical behavior is a key ingredient to the success of every insurance producer and to the insurance industry as a whole.

**Identifying What Is Not Ethics**

It is also important to identify what ethics is NOT:

- Ethics is not the same as feelings. Feelings provide important information for our ethical choices. Some people have highly developed habits that make them feel bad when they do something wrong, but many people feel good even though they are doing something wrong. And often our feelings will tell us it is uncomfortable to do the right thing if it is hard.
- Ethics is not religion. Many people are not religious, but ethics applies to everyone. Most religions do advocate high ethical standards but sometimes do not address all the types of problems we face.
- Ethics is not following the law. A good system of law does incorporate many ethical standards, but law can deviate from what is ethical. Law can become ethically corrupt, as some totalitarian regimes have made it. Law can be a function of power alone and designed to serve the interests of narrow groups. Law may have a difficult time designing or enforcing standards in some important areas, and may be slow to address new problems.
- Ethics is not following culturally accepted norms. Some cultures are quite ethical, but others become corrupt or blind to certain ethical concerns (as the United States was to slavery before the Civil War). "When in Rome, do as the Romans do" is not a satisfactory ethical standard.
- Ethics is not science. Social and natural science can provide important data to help us make better ethical choices. But science alone does not tell us what we ought to do. Science may provide an explanation for what humans are like. But ethics provides reasons for how humans ought to act. And just because something is scientifically or technologically possible, it may not be ethical to do it.

**Why Identifying Ethical Standards is Hard**

There are two fundamental problems in identifying the ethical standards we are to follow:

- On what do we base our ethical standards?
- How do those standards get applied to specific situations we face?

If our ethics are not based on feelings, religion, law, accepted social practice, or science, what are they based on? Many philosophers and ethicists have helped us answer this
critical question. They have suggested at least five different sources of ethical standards we should use. They are:

- **The Utilitarian Approach.** Some ethicists emphasize that the ethical action is the one that provides the most good or does the least harm, or, to put it another way, produces the greatest balance of good over harm. The ethical corporate action, then, is the one that produces the greatest good and does the least harm for all who are affected-customers, employees, shareholders, the community, and the environment. The utilitarian approach deals with consequences; it tries both to increase the good done and to reduce the harm done.

- **The Rights Approach.** Other philosophers and ethicists suggest that the ethical action is the one that best protects and respects the moral rights of those affected. This approach starts from the belief that humans have a dignity based on their human nature per se or on their ability to choose freely what they do with their lives. On the basis of such dignity, they have a right to be treated as ends and not merely as means to other ends. The list of moral rights-including the rights to make one's own choices about what kind of life to lead, to be told the truth, not to be injured, to a degree of privacy, and so on-is widely debated; some now argue that non-humans have rights, too. Also, it is often said that rights imply duties-in particular, the duty to respect others' rights.

- **The Fairness or Justice Approach.** Aristotle and other Greek philosophers have contributed the idea that all equals should be treated equally. Today we use this idea to say that ethical actions treat all human beings equally-or if unequally, then fairly based on some standard that is defensible. We pay people more based on their harder work or the greater amount that they contribute to an organization, and say that is fair.

- **The Common Good Approach.** The Greek philosophers have also contributed the notion that life in community is a good in itself and our actions should contribute to that life. This approach suggests that the interlocking relationships of society are the basis of ethical reasoning and that respect and compassion for all others-especially the vulnerable-are requirements of such reasoning. This approach also calls attention to the common conditions that are important to the welfare of everyone. This may be a system of laws, effective police and fire departments, health care, a public educational system, or even public recreational areas.

- **The Virtue Approach.** A very ancient approach to ethics is that ethical actions ought to be consistent with certain ideal virtues that provide for the full development of our humanity. These virtues are dispositions and habits that enable us to act according to the highest potential of our character and on behalf of values like truth and beauty. Honesty, courage, compassion, generosity, tolerance, love, fidelity, integrity, fairness, self-control, and prudence are all examples of virtues. Virtue ethics asks of any action, "What kind of person will I become if I do this?" or "Is this action consistent with my acting at my best?"

Each of the above approaches helps us determine what standards of behavior can be considered ethical. There are still problems to be solved, however.
The first problem is that we may not agree on the content of some of these specific approaches. We may not all agree to the same set of human and civil rights. We may not agree on what constitutes the common good. We may not even agree on what is a good and what is a harm.

The second problem is that the different approaches may not all answer the question "What is ethical?" in the same way. Nonetheless, each approach gives us important information with which to determine what is ethical in a particular circumstance. And much more often than not, the different approaches do lead to similar answers.

Making Ethical Decisions

As an insurance producer/financial advisor, you are constantly put on the spot to make ethical decisions. So, how do you know if the decision you are about to make is ethical?

According to the Markkula Center for Applied Ethics at Santa Clara University (www.scu.edu/ethics-center), making good ethical decisions requires a trained sensitivity to ethical issues and a practiced method for exploring the ethical aspects of a decision and weighing the considerations that should impact our choice of a course of action. Having a method for ethical decision making is absolutely essential. When practiced regularly, the method becomes so familiar that we work through it automatically without consulting the specific steps.

The more novel and difficult the ethical choice we face, the more we need to rely on discussion and dialogue with others about the dilemma. Only by careful exploration of the problem, aided by the insights and different perspectives of others, can we make good ethical choices in such situations. Here is a framework recommended by the Markkula Center for Applied Ethics that can be a useful method for exploring ethical dilemmas and identifying ethical courses of action.

- Recognize an Ethical Issue.
  - Could this decision or situation be damaging to someone or to some group? Does this decision involve a choice between a good and bad alternative, or perhaps between two "goods" or between two "bads"?
  - Is this issue about more than what is legal or what is most efficient? If so, how?
- Get the Facts.
  - What are the relevant facts of the case? What facts are not known? Can I learn more about the situation? Do I know enough to make a decision?
  - What individuals and groups have an important stake in the outcome? Are some concerns more important? Why?
  - What are the options for acting? Have all the relevant persons and groups been consulted? Have I identified creative options?
• Evaluate Alternative Actions. Evaluate the options by asking the following questions:
  o Which option will produce the most good and do the least harm? (The Utilitarian Approach)
  o Which option best respects the rights of all who have a stake? (The Rights Approach)
  o Which option treats people equally or proportionately? (The Justice Approach)
  o Which option best serves the community as a whole, not just some members? (The Common Good Approach)
  o Which option leads me to act as the sort of person I want to be? (The Virtue Approach)

• Make a Decision and Test It
  o Considering all these approaches, which option best addresses the situation?
  o If I told someone I respect which option I have chosen, what would they say?

• Act and Reflect on the Outcome
  o How can my decision be implemented with the greatest care and attention to the concerns of all stakeholders?’
  o How did my decision turn out and what have I learned from this specific situation?

Let me share with you another ethical guide you should consider using when making ethical decisions, it’s called—“The Four-Way Test”.

**The Four-Way Test**

The 4-Way Test was penned by businessman, Herbert J. Taylor, in 1932. It was designed as a foundation for ethical decision making. The Rotary International adopted the test in the 1940’s. Since that time, the test has been introduced in schools, governments and businesses worldwide, as a yardstick for principle-based living. Ask yourself the following:

- First: Is it the TRUTH?
- Second: Is it FAIR to all concerned?
- Third: Will it build GOODWILL & BETTER FRIENDSHIP?
- Fourth: Will it be BENEFICIAL to all concerned?

The Four-Way Test can serve us as a trusted ethical guide. Through it, you are pointed to the ethics of principle. Through it you are pointed to the ethics of practicality. But as responsible, insurance producers, you are trusted to recognize the differences. You are expected to apply both principle and practicality in an ethically mature way.
It is not enough that you ASK the four questions. It is not enough that you make a decision based on some ONE of the questions. The Four-Way Test is not only your call to lofty principles and to beneficial practicality – it is your challenge to combine them in ethically responsible decisions and actions.

Next let’s review probably the most famous ethical principle: The Golden Rule.

**The Golden Rule**

The most famous ethical principle is the golden rule, which states

“*Do unto others as you would have them do to you.*”

Known as “the golden rule,” this rule implies that an ethical person is concerned not only with themselves but also with the well-being of others. This principle describes a "reciprocal", or "two-way", relationship between one's self and others that involves both sides equally, and in a mutual fashion. This entails always being honest, keeping promises, and respecting people and property.

The Golden Rule has a history that long predates the term "Golden Rule", or "Golden law", as it was called from the 1670s in England and Europe. As a concept of "the ethic of reciprocity," it has its roots in a wide range of world cultures, and is a standard way that different cultures use to resolve conflicts. It has a long history, and a great number of prominent religious figures and philosophers have restated its reciprocal, "two-way" nature in various ways (not limited to the above forms).

This principle can be explained from the perspective of psychology, philosophy, sociology and religion.

- Psychologically, it involves a person empathizing with others. Philosophically, it involves a person perceiving their neighbor as also an “I” or “self.”
- Sociologically, this principle is applicable between individuals, between groups, and also between individuals and groups. (For example, a person living by this rule treats all people with consideration, not just members of his or her in-group.)
- Religions figure prominently in the history of this concept.

The golden rule is endorsed by all the great world religions; Jesus, Hillel, and Confucius used it to summarize their ethical teachings (see Table 1.1). And for many centuries the idea has been influential among people of very diverse cultures. These facts suggest that the golden rule may be an important moral truth.
<table>
<thead>
<tr>
<th>Religion</th>
<th>Passage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahá'í Faith</td>
<td>&quot;Ascribe not to any soul that which thou wouldst not have ascribed to thee, and say not that which thou dost not.&quot; &quot;Blessed is he who preferreth his brother before himself.&quot; Baha'u'llah</td>
</tr>
<tr>
<td>Brahmanism</td>
<td>&quot;This is the sum of Dharma [duty]: Do naught unto others which would cause you pain if done to you.&quot; Mahabharata, 5:1517</td>
</tr>
<tr>
<td>Buddhism</td>
<td></td>
</tr>
</tbody>
</table>
"...a state that is not pleasing or delightful to me, how could I inflict that upon another?" Samyutta Nikaya v. 353 Hurt not others in ways that you yourself would find hurtful." Udana-Varga 5:18 |
| Christianity | "Therefore all things whatsoever ye would that men should do to you, do ye even so to them: for this is the law and the prophets." Matthew 7:12, King James Version.  
"And as ye would that men should do to you, do ye also to them likewise." Luke 6:31, King James Version.  
"...and don't do what you hate...", Gospel of Thomas 6. The Gospel of Thomas is one of about 40 gospels that circulated among the early Christian movement, but which never made it into the Christian Scriptures (New Testament). |
| Confucianism | "Do not do to others what you do not want them to do to you" Analects 15:23  
"Tse-kung asked, 'Is there one word that can serve as a principle of conduct for life?' Confucius replied, 'It is the word 'shu' -- reciprocity. Do not impose on others what you yourself do not desire.'" Doctrine of the Mean 13.3  
"Try your best to treat others as you would wish to be treated yourself, and you will find that this is the shortest way to benevolence." Mencius VII.A. |
| Ancient Egyptian | "Do for one who may do for you, that you may cause him thus to do." The Tale of the Eloquent Peasant, 109 - 110 Translated by R.B. Parkinson. The original dates to circa 1800 BCE and may be the earliest version of the Epic of Reciprocity ever written. |
| Hinduism     | "This is the sum of duty: do not do to others what would cause pain if done to you." Mahabharata 5:1517                                                                 |
| Islam        | "None of you [truly] believes until he wishes for his brother what he wishes for himself." Number 13 of Imam "Al-Nawawi's Forty Hadiths."                                                                 |
| Jainism:     | "Therefore, neither does he [a sage] cause violence to others nor does he make others do so." Acarangasutra 5.101-2.  
"In happiness and suffering, in joy and grief, we should regard all creatures as we regard our own self." Lord Mahavira, 24th Tirthankara  
"A man should wander about treating all creatures as he himself would be treated. "Sutrakritanga 1.11.33 |
| Judaism      | 
"...thou shalt love thy neighbor as thyself.". Leviticus 19:18  
"What is hateful to you, do not to your fellow man. This is the law: all the rest is commentary." Talmud, Shabbat 31a.  
"And what you hate, do not do to any one." Tobit 4:15 |
| Taoism       | "Regard your neighbor’s gain as your gain, and your neighbor’s loss as your own loss." Tai Shang Kan Yin P’ien  
"To those who are good to me, I am good; to those who are not good to me, I am also good. Thus all get to be good." |
Zoroastrianism

"That nature alone is good which refrains from doing to another whatsoever is not good for itself." Dadisten-I-dinik, 94,5
"Whatever is disagreeable to yourself do not do unto others." Shayast-na-Shayast 13:29

All versions and forms of the proverbial *Golden Rule* have one aspect in common: they all demand that people treat others in a manner in which they themselves would like to be treated.

In closing this chapter, let me share with you the ten “Ethical Hazard Approaching” signs that have been developed by the Josephson Institute of Ethics to help individuals gauge their ethical decision making and 5-questions to ask yourself every day.

**The Ten “Ethical Hazard Approaching” Signs**

Michael Josephson, founder of the Josephson Institute Center for Business Ethics, highlights ten common rationalizations for unethical acts that serve as “ethical hazard approaching” signs. Each of the ten rationalizations contains additional contextual information that someone believes outweighs the initial gut feeling that the action is unethical.

Beware when someone says:

- It may seem unethical…but it is legal and permissible.
- It may seem unethical…but it is necessary.
- It may seem unethical…but it is just part of the job.
- It may seem unethical…but it is all for a good cause.
- It may seem unethical…but I am just doing it for you.
- It may seem unethical…but I am just fighting fire with fire.
- It may seem unethical…but it doesn’t hurt anyone.
- It may seem unethical…but everyone else is doing it.
- It may seem unethical…but I don’t gain personally.
- It may seem unethical…but I’ve got it coming.

Ethical behavior is a key ingredient to the success of every insurance producer and to the insurance industry as a whole.

**Insurance Producers as a Professional**

Insurance producers, including this producer, have long sought to distinguish ourselves as professionals on a plane with law, medicine and education. A professional is defined as a person in an occupation requiring an advanced level of training, knowledge, or skill.

Professionals enjoy rights commensurate with their skills, but they also have higher responsibilities in caring for others because of the title of professional.
Do you consider yourself to be a professional? Review the following five commonly accepted characteristics of a professional and see if you possess them:

- Commitment to high ethical standards.
- Concern for the welfare of others (place public interest above self-interest).
- Meeting mandatory licensing and training requirements (maintain a high degree of competence).
- Formal participation in an association or society.
- Acting with integrity and objectivity.

Do you possess these characteristics? Are you a professional insurance producer?
Chapter 1
Review Questions

1. Ethics answers the question?
   ( ) A. Who am I?
   ( ) B. What I get?
   ( ) C. What do I do?
   ( ) D. What are the consequences?

2. The study of ethics began with the:
   ( ) A. Greeks
   ( ) B. Italians
   ( ) C. Turks
   ( ) D. Spanish

3. Ethics is the branch of study dealing with:
   ( ) A. Deciding who is responsible for one’s decisions
   ( ) B. The proper course of action for man
   ( ) C. Being responsible
   ( ) D. Being Irresponsible

4. Who is credited with writing “The 4-Way Test”?
   ( ) A. Albert Einstein
   ( ) B. David Callahan
   ( ) C. Herbert J. Taylor
   ( ) D. Aristotle

5. Which of the following is a key ingredient to the success of an insurance producer?
   ( ) A. Unethical sales practices
   ( ) B. Sales to unsuitable clients
   ( ) C. Ethical behavior
   ( ) D. Generating sales without considering the needs of the client
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Overview

As an industry, we need to refocus our attention to our ethical responsibilities. It’s unfortunate that unethical acts of a relatively few individuals cast a shadow on the majority of insurance producers who have always conducted themselves according to the highest ethical standards. The many ethical insurance producers are the people to whom the insurance industry owes its success, and they deserve some credit.

However, the reality is, there will always be a few “bad apples,” as there will be in any industry. But we can’t let that be an excuse for complacency. It is important that all insurance producers understand the ethical dimensions of some of the issues our industry faces. The goal of ethics education is to create a win-win environment for all parties who hold a stake in the continuing success of the insurance industry: the insurer and their employees, insurance producers, policyowners, beneficiaries, the general public, and state and federal regulators.

In this chapter we will review the history of insurance, the role that insurance plays, and discuss the most fundamental principle of the insurance industry: trust. It will also examine the ethical responsibilities of the insurance producer and the insurer.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Distinguish the role and importance of insurance to consumers;
- Recognize the importance of trust in the insurance industry;
- Apply the ethical responsibilities of the insurance producer; and
- Identify the ethical responsibilities of the insurer to the insurance producer and to the consumer.

Let’s first define what insurance is.

Insurance Defined

Insurance is a social device for spreading the chance of financial loss among a large number of people. By purchasing insurance, a person shares risk with a group of others,
reducing the individual potential for disastrous financial consequences. Insurance is a financial asset that helps to reduce those adverse consequences (risks).

- **Financial definition**: A financial arrangement for redistributing the costs of unexpected losses.
- **Legal definition**: A contractual arrangement whereby one party agrees to compensate another party for losses.
- **Bell’s Definition**: An economic device whereby insured’s transfer potentially large uncertain financial risks to the insured group (usually through an insurance company) in exchange for a relatively small certain payment (the premium).

**The Role and History of Insurance**

Insurance plays a major role in the lives of most people in the United States. Every day, all of us face various risks; such as the risk of unemployment, disability, sickness, premature death, damage or loss of our property, and even living too long. These risks evolve from uncertainty which result in personal financial loss. Risk is the possibility that a loss might occur and is one of the reasons that people purchase insurance.

**History of Insurance**

Insurance originated back in the 13th century with ship owners who wanted to insure their ships and cargo against the loss at sea. These ship owners met at coffee houses to transact business with groups of wealthy individuals willing to insure property against potential loss. The leading coffee house eventually became Lloyd’s of London in the 17th century. Fire insurance was first offered in the 16th century. In the United States, the first fire insurance company was started in 1752 by Benjamin Franklin, and was known as the Philadelphia Contributionship for the Insurance of Houses from Loss by Fire.

The insurance company receives relatively small amounts of money, referred to as premium, from each of the large number of people buying insurance. A large uncertain loss is exchanged for a specific small amount of premium.

The agreement between the insurer and the insured, the person covered by the insurance, is established in a legal document referred to as a contract of insurance or a policy. The insurer promises to pay the insured according to the term of the policy if a loss occurs. Loss is defined as reduction in the value of an asset. To be paid for a loss, the insured must notify the insurer by making a claim. The claim is a “demand” for payment of the insurance benefits to the person named in the policy.

The costs and benefits of insurance to society are obvious. Due to the sharing, or pooling, of a large number of similar risks, insurance coverage is available to most individuals for a reasonably affordable premium. When losses occur, insurance helps individuals to maintain their customary standard of living, which helps the whole
economy. Insurance is the device that allows individuals and society in general to recover from unexpected losses.

It is because of this unique role of insurance that it is more important for the insurance industry to maintain a high ethical standard.

**The Importance of Trust in the Insurance Industry**

The basic insurance product is an uncertain promise that the insurer may never be called upon to fulfill. The value of the promise is based on the trust of the policyholder in the insurer. Without trust, insurance cannot perform its proper function as a risk management device for companies and individuals.

No industry depends more on trust than the insurance industry, and this trust comes from a series of events in which ethical values are demonstrated. For instance, a life insurance policy might provide coverage for decades, although it’s only a piece of paper. That piece of paper, however, commands a series of premium payments totaling thousands of dollars over many years. The same piece of paper, in return, promises a large payment sometime in the future. Trust is a fundamental principle of insurance.

“To be trusted is a greater compliment than to be loved”

George MacDonald

However, year after year, consumers have rated insurance companies as one of the lowest industries when it comes to trust. In fact it is well documented that the level of trust in the financial and insurance services industry remains unchanged and relatively low. For example, The 2014 Edelman Trust Barometer rates the financial/insurance services at the bottom of the table of trusted industries, well below even sectors such as energy, pharmaceuticals and brewing and spirits. According to the Edelman Trust barometer, the best that can be said is that the level of trust has increased slightly – but by just 1% on average globally over the past year. Clearly, financial institutions face a huge task to convince the world that they are changing and establishing some integrity in their operations.

Only 48% of people globally trust financial services, according to the Edelman Trust Barometer 2014 – a global survey of attitudes to banks, insurers, other financial institutions and other industries. New York based public relations firm Edelman has been surveying attitudes to business in general since 2000, but only began looking at financial services as a separate group in 2011. Since then, trust in the sector has risen from 46% to 48%, but stagnated there. This compares with 79% who trust the technology sector (up 2% since 2013), 75% who trust consumer electronics manufacturing (also up 2% since 2013) and 70% who trust the automotive sector (up 1%). Interestingly, the industry that vies most often with financial services for bottom place is the media (see Figure 2.1).
Figure 2.1
Trust In Industries

There is some divergence across the sector. Banks, credit cards and payments are trusted by 52%, whereas insurance scores 47% and financial advisory and asset management languish at 46% (see Figure 2.2).

Figure 2.2
Trust In Financial Services Industries

Since 1997, in every Gallup poll entitled Honesty/Ethics, consumers have consistently ranked insurance salespersons and insurance companies among the lowest in terms of perceived honesty and ethical standards. Figure 2.3 illustrates the most recent Gallup
Poll (2014) that rates the insurance salesperson with only 15% of the people surveyed listed the insurance salesperson at very high or high to be ethical and honest.


“...the fall of trust in the United States over the past forty years has long been discussed and debated. It is a well-known fact that Americans trust nearly every institution less than we used to. We are less trusting of government, less trusting of the media, less trusting of religious institutions, and less trusting of lawyers and other professions.”

**Outlook for Ethics in the Insurance Industry**

Let’s face it, the consumer’s attitudes towards insurance are changing, and their expectations are rising. Regulatory changes point to the need for a new mind-set in conduct and culture by both insurance producers and insurers. In an insurance market in a changing world, it will be down to the insurance producer acting professionally to confront the issues and challenges to ensure that trust and confidence is aligned with the traditional strengths of the insurance market.

As an industry, we need to refocus our attention to our ethical responsibilities. It’s unfortunate that unethical acts of a relatively few individuals cast a shadow on the majority of insurance producers who have always conducted themselves according to the highest ethical standards. The many ethical insurance producers are the people to whom
the life insurance industry owes its success, and they deserve some credit. It can be very
discouraging when instead of getting it, they are painted with the same broad-brush as a
few “bad apples.” Here are a few ideas that professional insurance producers should
keep in mind.

- Researchers suggest that ethical sales behavior can lead to more client trust and
  that insurance producers who engage in customer-oriented behavior are more
  likely to have long term satisfied customers and are less likely to engage in
  unethical activities. (Legace, Dahlstrom and Gassenheimer 1991 Journal of
  Personal Selling and Sales Management)
- The consequences of unethical behavior are particularly unpleasant for those who
  engage in it. Penalties often involve loss of one’s license, fines and civil liability
  for monetary damages, in addition to personal disgrace. Unethical people do get
  caught. And even if there are a few who don’t, it’s not worth the risk.
- So what’s the bottom line on being ethical? For ethical people, self-respect (being
  able to look into the mirror and like what you see) is more important than any
  reward someone else could offer. That fact doesn’t change even when unethical
  people seem to benefit from their behavior or when ethical behavior goes
  unrecognized. Ethical people do the right thing just because it’s the right thing to
do.

The reality is, there will always be a few “bad apples” in the life insurance business, as
there will be in any industry. But we can’t let that be an excuse for complacency. Courses
like this one are part of an effort to make the life insurance industry’s implicit
commitment to ethics more explicit. Even persons who are not inclined toward unethical
behavior can benefit from understanding the ethical dimensions of some of the issues our
industry faces. The goal of ethics education is to create a win-win environment for all
parties who hold a stake in the continuing success of the life insurance industry: the
insurer and their employees, insurance producers, policyowners, beneficiaries, the
general public, and state and federal regulators.

Next, let’s examine some of the ethical responsibilities that are squarely placed on the
shoulders of the insurance producer.

**Ethical Responsibilities of the Insurance Producer**

There are three areas of ethical responsibility for an insurance producer:

- *Responsibility to the Insurer*. Responsibilities to the agent's insurer are covered
  under the concept of agency. The agent owes his or her insurer the duties of good
  faith, honesty and loyalty. The agent's day-to-day activities are a direct reflection
  of the insurer's “image” within the community.
- *Responsibility to the Insured/Policy Owner*. Responsibilities to policy owners
  require the agent to meet the needs of the client, provide quality service, maintain
  loyalty, confidentiality, timely submission of applications and prompt policy
delivery. Responsibilities to the public require the agent to maintain the highest level of professional conduct and integrity in all public contact in order to maintain a strong positive image of the industry.

- **Responsibility to the State.** Responsibilities to the state require the agent to adhere to the ethical standards mandated by his or her state.

Let’s review each of these ethical responsibilities in greater detail.

**Insurance Producer’s Ethical Responsibilities to the Insurer**

The insurance producer's contract or agency agreement with the insurer will specify the producer’s (agent's) duties and responsibilities to the principal. In all insurance transactions, the insurance producer’s responsibility is to act in accordance with the agency contract and thus for the benefit of the insurer. If the insurance producer is in violation of the agency agreement, then he or she may be held personally liable to the insurer for breach of contract.

An insurance producer has a duty to act with a degree of care that a reasonable person would exercise under similar circumstances. This **prudent person rule** is to protect the insurer and the insured from unreasonable insurance transactions on the part of the insurance producer (agent).

In accordance with the insurance producer’s fiduciary obligation to the insurer and his or her agency agreement, the insurance producer has a responsibility of accounting for all property, including money that comes into his or her possession. The insurance producer must not embezzle or commingle these funds.

As part of the insurance producer’s working relationship with the insurer, it is important that pertinent information be disclosed to the insurer, particularly with regard to underwriting and risk selection. If the insurance producer knows of anything adverse concerning the risk to be insured, it is his or her responsibility to provide this information to the insurer. To withhold important underwriting information could adversely affect the insurer's risk selection process. In accordance with agency law, information given to the insurance producer is the same as providing the information to the insurer.

It is the insurance producer's responsibility to obtain necessary information from the insurance applicant and to accurately complete the application for insurance. A signed and witnessed copy of the application becomes part of the legal contract of insurance between the insured and the insurer.

Finally, the insurance producer has a responsibility to deliver the insurance policy to the insured and collect any premium that might be due at the time of delivery. The insurance producer must be prepared to provide the insured with an explanation of some of the policy's principal benefits and provisions. If the policy is issued with any changes or amendments, the insurance producer will also be required to explain these changes and obtain the insured’s signature acknowledging receipt of these amendments.
Insurance Producer’s Ethical Responsibility to Insured/Policy Owner

An insurance producer has a fiduciary duty to just about any person or organization that he or she comes into contact with as part of the day-to-day business of transacting insurance. By definition, a fiduciary is a person in a position of financial trust. Thus, attorneys, accountants, trust officers, and insurance producers (agents) are all considered fiduciaries.

As a fiduciary, the insurance producer has an obligation to act in the best interest of the insured (policy owner). The insurance producer must be knowledgeable about the features and provisions of various insurance policies and the use of these insurance contracts. The insurance producer must be able to explain the important features of these policies to the insured. The insurance producer must recognize the importance of dealing with the general public's financial needs and problems and offer solutions to these problems through the purchase of insurance products.

As a fiduciary, the insurance producer must collect and account for any premiums collected as part of the insurance transaction. It is the insurance producer’s duty to make certain that these premiums are submitted to the insurer promptly. Failure to submit premiums to the insurer, or putting these funds to one's own personal use, is a violation of the insurance producer’s fiduciary duties and possibly an act of embezzlement.

The insured’s premiums must be kept separate from the insurance producer’s personal funds. Failure to do this can result in commingling—mixing personal funds with the insured or insurer's funds.

Insurance Producer’s Ethical Responsibilities to the State

Since states regulate the insurance industry, you as a licensed insurance producer are required to meet the state’s rules, regulations and legislation to protect the consumer. States through an Insurance Commissioner or Director oversee the marketing activities of insurance producers as a licensed insurance producer, you are required to have a license in the state (s) you are conducting business in and as a licensed agent in that state(s), you are required to meet the ethical conduct as set forth in the state’s Insurance Code and abide by the state’s administrative code as set forth by the state department of insurance.

Next, let’s review the insurer’s ethical responsibility to the insurance producer

Insurer’s Responsibility to the Insurance Producer

Because the insurer (the principal) is obligated and responsible for the actions of his or her insurance producers (agents) it is imperative that the insurer chooses individuals of the highest caliber of ethical conduct.
The obligation of both the insurer and the producer are spelled out in an employment agreement. The insurer has three major duties to the producer:

- Employment
- Compensation
- Indemnification

The Employment Agreement

The employment agreement covers the following elements:

- Length of time
- Minimum production standards
- Lines of business that may be written
- Method of compensation
- Insurer’s recourse for non-performance

The Insurer’s Obligation of Compensation

In exchange for representation the insurer compensates the producer based on the terms of the employment agreement. Compensation is broken down depending on the nature of the business and whether it is new business or renewal business. The most common breakdown is as follows:

- Different rates for different lines of insurance
- Higher rate of commission on new business
- Lower rate of commission on renewal business

Due to this type of structure sometimes producers may shift policyholders from one company to another company at renewal time. An ethical producer must never do this at the expense of the client.

Indemnification of Producer

Unless the producer is found guilty of breach of duty or lacking in due diligence, the insurer indemnifies the producer from all costs and claims made against him or her in the carrying out of his or her agency relationship with the insurer.

Potential Liabilities of Insurance Producers/Errors and Omissions (E&O) Exposure

Errors and omissions (E&O) insurance is needed by professionals who give advice to their clients. It covers negligence, error, or omission by the insurer or producer who is the insurer's representative. E&O policies protect producers from financial losses they may suffer if insured’s sue to recover for their financial loss due to a producer giving them
incorrect advice (error) or not informing them of an important issue (omission). Because a producer's office is very busy, he or she must take special care to follow strict procedures in regard to taking applications, explaining coverage, collecting premiums, submitting changes to policies upon an insured’s request, and preparing claim forms. Any error or omission could result in losing a client and could lead to a lawsuit. All E&O insurance policies have certain basic characteristics in common:

- The policy covers only losses due to negligence, error, or omission. For example, the agent who fails to tell a client that his or her purchase of a new policy means that waiting periods have to be met again can be sued for this omission if the event previously covered occurs and the insured finds that he or she is not currently covered.
- The policy usually has a high deductible, such as $500 or $1,000. The high deductible provides an added incentive for a producer to reduce his or her errors.
- The coverage may be written with both a limit per claim, and a limit for all claims during the policy period.
- Except for obvious exclusions, like a producer committing unfair trade practices, the policy has few other exclusions.

**Agency Law Principles**

An understanding of the law of agency is important because an insurance company, like other companies, must act through agents.

Agency is a relationship in which one person is authorized to represent and act for another person or for a corporation. Although a corporation is a legal "person," it cannot act for itself, so it must act through agents. An agent is a person authorized to act on behalf of another person, who is called the principal. In the field of insurance, the principal is the insurance company and the insurance producer is the agent. When one is empowered to act as an agent for a principal, he or she is legally assumed to be the principal in matters covered by the grant of agency. Contracts made by the agent are the contracts of the principal. Payment to the agent, within the scope of his or her authority, is payment to the principal. The knowledge of the agent is assumed to be the knowledge of the principal.

The two fundamental principles of an agency relationship are power and authority and the high standards of conduct expected of the agent as a fiduciary

**Presumption of Agency**

If a company supplies an individual with forms and other materials (signs and evidences of authority) that make it appear that he or she is an agent of the company, a court will likely hold that a presumption of agency exists. The company is then bound by the acts of this individual regardless of whether he or she has been given this authority. The agent’s ethical behavior is of utmost concern in carrying out the principal’s instructions.
Power of Authority

An insurance producer (agent) has one of three types of authority. They are:

- Express Authority
- Implied Authority
- Apparent Authority

Let’s review each of these in greater detail.

Express Authority

*Express Authority* is an explicit, definite agreement. It is the authority the principal gives the insurance producer as set forth in his or her contract.

Implied (Lingering) Authority

*Implied authority* is not expressly granted under an agency contract, but it is actual authority that the insurance producer has to transact the principal's business in accordance with general business practices.

**For Example:** If an insurance producer’s contract does not give him or her express authority of collecting and submitting the premium, but the insurance producer does on a regular basis, and the company accepts the premium, the insurance producer is said to have implied authority.

*Lingering implied authority* means that the insurance producer carries "signs or evidences of authority." By having these evidences of authority, an insurance producer who is no longer under contract to an insurer could mislead applicants or insured’s. When the agency relationship between insurance producer and company has been terminated, the company will try, or should try, to get back all the materials it supplied to the former insurance producer, including sales materials.

On the other hand, the public cannot assume that an individual is a producer agent merely because he or she says so. The insurance producer must carry the credentials (for example, the insurance producer’s license and appointment) and company documents (such as applications and rate books) that represent him or her as being an insurance producer for an insurance company.

Apparent Authority

*Apparent authority* is the authority the agent seems to have because of certain actions undertaken on his or her part. This action may mislead applicants or insured’s, leading them to believe that the agent has authority that he or she does not, in fact, have. The principal adds to this impression by acting in a manner that reinforces the impression of authority. For instance, an agent's contract usually does not grant him the authority to
reinstate a lapsed policy by accepting past due premiums. If, in the past, the company has allowed the agent to accept late premiums for that purpose, a court would probably hold that the policy owner had the right to assume that the agent's acceptance of premiums was within the scope of his or her authority.

**Waiver and Estoppel**

The legal doctrines of waiver and estoppel are directly related to the responsibilities of insurance producers. An insurer may, by waiver, lose the right of making certain defenses that it might otherwise have available.

- **Waiver** is defined as the intentional and voluntary giving up of a known right. An insurance company may waive its right to cancel a policy for nonpayment by accepting late payments.
- **Estoppel** means that a party may be precluded by his or her acts of conduct from asserting a right that would act to the detriment of the other party, when the other party has relied upon the conduct of the first party and has acted upon it. An insurer may waive a right, and then after the policy owner has relied upon the waiver and acted upon it, the insurer will be estopped from asserting the right.

Waiver and estoppel often occur together, but they are separate and distinct doctrines. The insurance producer must be alert in his or her words, actions, and advice to avoid mistakenly waiving the rights of the insurance company. As a representative of the company the insurance producer's knowledge and actions may be deemed to be knowledge and actions of the company.

**Categories of Insurance Producers**

Insurance producers are not only categorized by their function in the industry, but also by the line of insurance they sell. They can be categorized and licensed as:

- Life and Health Agents
- Property and Casualty Agents
- Brokers
- Solicitors
- Insurance Consultants

**Note:** Every state requires that individuals who sell insurance have a license (resident or non-resident) from the state in which they conduct business in.

**Life and Health Producers (Agents)**

Generally, life and health producers (agents) represent the insurer to the consumer with respect to the sale of life and health insurance products. The insurance producer (agent) is appointed by the insurer and usually the agent’s authority to represent the insurer is
specified in the agency agreement between them, which is a working agreement between the insurance producer (agent) and the insurer. Life and health insurance producers (agents) generally do not have the authority to issue or modify insurance contracts. Customarily, life and health insurance producers (agents) are authorized to solicit, receive, and forward applications for the contracts written by their companies. The insurance producer (agent) may receive the first premium due with the application, but usually not subsequent premiums, except in industrial life insurance. The insurance company approves and issues the contract after receiving the application and premium from the applicant through the insurance producer (agent). The insurance producer (agent) cannot bind coverage. This means that an insurance producer (agent) cannot commit to providing insurance coverage on behalf of the insurance company.

**Property and Casualty Agents**

Insurance producers (agents) appointed by property and liability insurance companies generally are granted more authority. These agents may bind or commit their companies by oral or written agreement. They sometimes inspect risks for the insurance company and collect premiums due. They may be authorized to issue many types of insurance contracts from their own offices.

**Brokers**

In contrast to the agent-client relationship in which the agent represents the insurer to the purchaser, a broker legally represents the insured and acts as an independent contractor on behalf of his or her principal, the insured.

The broker’s role is to seek out the best he or she can find for his or her client, the insured, and represents that client’s best interest. Although the broker receives compensation from the insurer the amount of compensation should not become an ethical issue by serving his or her needs ahead of his or her principal’s needs. However, recent scandals on “bid rigging” with several large insurance brokers has brought unquestionable concerns about the role and ethics of those brokers and the industry as a whole.

Brokers must be licensed just like agents and generally their routine activities and functions are similar to that of agents. Brokers solicit applications for insurance, may collect the initial premium and deliver policies. Brokers do not have the authority to bind coverage.

Similar to an insurance producer (agent) who has certain ethical obligations to both the insurer and the insured, a broker also has obligations to the insurer even though his or her client is the insured. These obligations include:

- Disclosure of all pertinent information
- Carrying out obligations in a professional and diligent manner
- Seeking out quality business
- Competing fairly and ethically
- Acting promptly and diligently

Note: Some states do not license brokers, such as the State of Florida.

**Solicitors**

A solicitor is a salesperson who works for an agent or a broker. This working relationship is most common in the property and casualty insurance field. Most often the solicitor will be licensed as a solicitor. Depending on the state, the solicitor may obtain an agents or broker’s license. Solicitors normally have a working agreement with an agent or broker. In accordance with this agreement, the solicitor’s primary functions are to solicit insurance, collect initial premiums and deliver policies. Solicitors cannot bind coverage.

**Insurance Consultants**

A very small group of insurance professionals call themselves consultants. Consultants are not paid by commission for the sales of insurance policies. Instead, they work strictly for the benefit of insured’s, and are paid a fee by the insured’s they represent.

**Captive Agents vs. Independent Agents**

A captive agent is one who has signed an exclusive contract with one or more insurers. The captive agent must represent the interest of those insurers as their fiduciary in the highest and most reputable manner.

It would be unethical for a captive agent to represent more than one insurance company selling the same or similar policies. The insurer owns and maintains control of all accounts serviced by the captive agent and in return the captive agent is paid a salary and or commissions.

The captive agent has an obligation to disclose to the insurer his or her interest in any similar business or service that he or she renders regardless of whether he or she receives compensation. It is then up to the principal to determine if there exists a conflict of interest.

**Independent Agents**

Independent agents (producers) most often represent numerous companies and are paid on a commission basis. An independent agent owns all of his or her clients and will shop with various insurance companies to find the best product at the most economical price for the client.
However, because independent agents must often meet sales targets set by insurance companies to maintain their writing ability with that insurance company, the ethical issues this type of agent often faces, is the dilemma of getting the best deal for his or her client, verses meeting his or her target levels, or perhaps receiving the highest commission (conflict of interest).

To avoid these conflicts and potential ethical violations, the independent agent must follow the guidelines set forth for dual agency. Under these guidelines the independent agent represents:

- His or her client only during the process of helping the client select the insurance plan best suited to the client’s needs. It is up to the independent agent to see that the insurance policy is written properly to meet the client’s needs and intent.
- The insurance company when the insurance is being applied for and when it is in the underwriting process, in record keeping, in claims settlement or other insurer related activities.

Dual agency when practiced ethically can serve both the insurer and the client without conflict.

**Insurance Producers as a Professional**

Insurance producers, including this producer, have long sought to distinguish ourselves as professionals on a plane with law, medicine and education. A professional is defined as a person in an occupation requiring an advanced level of training, knowledge, or skill.

Professionals enjoy rights commensurate with their skills, but they also have higher responsibilities in caring for others because of the title of professional.

Do you consider yourself to be a professional?
Chapter 2
Review Questions

1. Insurance originated back in what century with ship owners who wanted to insure their ships and cargo against the loss at sea?

( ) A. 18th Century
( ) B. 15th Century
( ) C. 19th Century
( ) D. 13th Century

2. Which of the following industries depends more on trust than any other industry?

( ) A. Auto Industry
( ) B. Insurance Industry
( ) C. Financial Industry
( ) D. Newspaper Industry

3. Which of the following rules is to protect the insurer and the insured from unreasonable insurance transactions on the part of the insurance producer (agent).

( ) A. Prudent person rule
( ) B. Suitability rule
( ) C. One person per contract rule
( ) D. Duty of care rule

4. Which category of producer is granted more authority and is able to bind or commit their companies by oral and written agreement?

( ) A. Insurance broker
( ) B. Property and casualty agents
( ) C. Life and health agents
( ) D. Insurance consultants

5. Which of the following statements about an independent agent is FALSE?

( ) A. An independent agent must follow the dual agency rule
( ) B. An independent agent represents only one insurer
( ) C. An independent agent owns his clients
( ) D. An independent agent is paid on a commission basis
CHAPTER 3

REGULATION OF THE INSURANCE INDUSTRY

Overview

Insurance is a highly regulated industry. It is regulated to protect the public interest and to make sure insurance is available on an equitable basis. Regulation of the insurance industry is undertaken from several perspectives and is divided among a number of authorities.

In this chapter, we will examine the history of the regulation of the insurance industry between the federal and state governments, and review the purposes for regulation. It will also examine the role of the National Association of Insurance Commissioners (NAIC) and examine several pieces of federal legislation affecting the insurance industry.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Distinguish between the role of the federal government vs. state government in the regulation of the insurance industry;
- Identify the state government structure for the regulation of the insurance companies doing business within their states;
- Identify the role of the state insurance departments in the regulation of insurance; and
- Define the role of the National Association of Insurance Commissioners in the regulation of the insurance industry.

Background

Benjamin Franklin helped found the insurance industry in the United States in 1752 with the Philadelphia Contributionship for the Insurance of Houses from Loss by Fire. Back then the Commerce Clause of the United States Constitution, Article I, section 8, clause 3, provided that:

"Congress shall have power...to regulate Commerce...among the several states."

And, it would seem that, because most insurance companies in many states, insurance sales is interstate commerce, and, therefore, subject to the jurisdiction of the federal
government. So, this clause gave the Federal government the power to regulate insurance as a means to oversee those areas not covered by state regulation of the industry.

However, in 1868, the Supreme Court first found, in the case of Paul v. Virginia, that insurance was not interstate commerce, and, thus, the states had the right to regulate insurance.

**Paul vs. Virginia**

In *Paul v. Virginia* (75 US 168 (1869), the U.S. Supreme Court upheld a Virginia statute requiring out-of-state insurers and their agents to obtain a license before conducting business within the state. The Court held that insurance was not commerce within the meaning of the Commerce Clause, and therefore, states held exclusive regulatory authority over the business of insurance.

For 75 years following the Paul decision, state authority over insurance regulation was unquestioned. The states created a vast and pervasive network of laws, regulations, taxes, and cooperative accounting practices.

**South-Eastern Underwriters Association (SEUA)**

In 1944, the Supreme Court reviewed its decision in *Paul* in *United States v. South-Eastern Underwriters Association* (322 U.S. 5433 (1944)). The South-Eastern Underwriters Association, a rate making organization, was charged with restraining commerce in violation of the Sherman Antitrust Act by fixing and enforcing arbitrary and noncompetitive premium rates. The Supreme Court rejected South-Eastern’s claim that the Sherman Anti-Trust Act did not apply because, under *Paul*, insurance is not commerce. The Court reversed its holdings in Paul and ruled that insurance is commerce, and when transacted across state lines, it is interstate commerce subject to federal law, including the Sherman Antitrust Act. As a result of (Paul), the constitutionality of all states statutes regulating the insurance business was called into question and a state of confusion reigned. Congress, unlike the states, had passed no laws specifically regulating the business of insurance.

However, changing the entire industry was not that easy. Bureaucracies and insurance companies had developed an understanding—some would say cozy relationship. The states already had many rules and regulations governing insurance, whereas the federal government had virtually none. Furthermore, it raised the possibility that the states did not have the right to tax insurance.

**McCarran-Fergusson Act**

In response to the SEUA decision, the federal government passed the McCarran-Ferguson Act in 1945 (this Act is also known as *Public Law 15* (Chapter 20, 59 Stat. 33, 1945, codified in 15 U.S.C. 1011-15). The Act stipulated that it was in the public interest.
to have the states regulate insurance, and that the insurance industry would not be subject to federal antitrust laws if it was regulated by state law.

The Act granted states the power to regulate the business of insurance, removing all Commerce Clause limitations on the states’ authority in this area. Congress’ authority to delegate this power to the states under the Commerce Clause was upheld by the Supreme Court in the 1946 case of *Prudential Ins. Co. v. Benjamin*.

However, a provision in the McCarran-Ferguson Act would permit the federal government to resume control over the regulation of the business of insurance if state regulation becomes inadequate. The McCarran-Ferguson Act allows Congress to enact legislation invalidating, impairing, or superseding state law, if the legislation “specifically relates to the business of insurance (15 U.S.C. 1012 (b)).

**State Regulation of the Insurance Industry**

The primary state insurance regulatory functions remain as they have been since the enactment of McCarran-Ferguson. This allows the states to perform solvency oversight of the U.S. insurance industry and to regulate insurer and insurance producers behavior in the marketplace.

**Structure of the State Regulatory Framework**

The regulatory framework is not confined to insurance departments but extends to all levels and branches of state government (see Figure 3.1). The major authorities in the current regulatory system are:

- The executive branch at the state level;
- State legislatures;
- The courts; and
- State insurance departments.

The body of laws at the state level is called the Insurance Code. State regulation consists of Statutes, and rules and regulations. Statutes are the body of law developed by the Legislature branch of government. They outline, in general terms, the duties of the Commissioner and the activities of the Insurance Department. Rules and regulations are developed by the Insurance Department to expand upon statutory requirements and carry out legislative intent.
The Role of the State Legislators

State legislators are the public policymakers that establish broad policy for the regulation of insurance by enacting legislation providing the regulatory framework under which insurance regulators operate. They establish laws which grant regulatory authority to regulators and oversee state insurance departments and approve regulatory budgets. State insurance departments employ 11,600 regulatory personnel (2010 figures). Increases in staff and enhanced automation have allowed regulators to substantially boost the quality and effectiveness of their financial oversight of insurers and expand consumer protection activities.

State regulation of insurance provides a major source of state revenue. In 2010, states collected roughly $18.6 billion in revenues from insurance sources. Of this amount, $1.24 billion—roughly 6.7 percent—went to regulate the business of insurance while the remaining revenues went to state general funds for other purposes.

The state legislature establishes the insurance department, enacts insurance laws and approves the regulatory budget. Insurance departments are part of the state executive branch, either as a stand-alone agency or as a division within a larger department.

Commissioners must often utilize the courts to help enforce regulatory actions, and the courts in turn, may restrict regulatory action. The insurance department in a given state must coordinate with other state insurance departments in regulating multistate insurers and rely on the NAIC for advice as well as some support services. The federal government overlays this entire structure, currently delegating most regulatory responsibilities to the states, while retaining an oversight role and intervening in specific areas.

State Insurance Departments
The Insurance Code of each state authorizes the establishment of an Insurance Department to administer and carry out the insurance laws. State insurance departments handle the daily affairs of the insurance industry, and spread more specialized administrative rules for the industry that has the force of law.

**Insurance Commissioner**

In each state, a public official will head the Insurance Department—the title of the official will be the Commissioner, Superintendent, or Director of Insurance. The title differs from state-to-state. However, a majority of the states use the title “Commissioner.” State Insurance Commissioners can be either an elected official (no less than 12 states, two of those states being those most populous in the nation), or be duly appointed by their elected governors. In all cases, the public official in charge of the Insurance Department has broad powers to supervise and regulate the insurance affairs within the state.

The insurance laws of the state usually confer upon the Commissioner all of the following powers and duties:

- To conduct investigations and examinations
- To make reasonable rules and regulations
- To hire employees, and examiners, and delegate any power, duty, or function to such persons
- To examine the accounts, records, documents, and transactions of any insurer, agent or broker
- To subpoena witnesses and administer oaths in order to further any examination, investigation, or hearing on insurance matters
- To issue orders and notices on decisions made or matters pending
- To impose penalties for violations of the Insurance Code, including but not limited to fines, suspension or revocations of license and Certificate of Authority, and requesting that the Attorney General prosecute a violator
- To approve insurance policy forms sold within the state
- To approve rates and rate increases for regulated lines of insurance

Insurance commissioners in every state belong to the National Association of Insurance Commissioners (NAIC). The NAIC reviews industry regulations and drafts model laws and policy forms for the states. Even though the NAIC has no legal authority, the states generally adopt their suggestions.

One of the state’s Insurance Commissioner’s duties is to handle customer complaints. He or she generally has a staff that handles customer complaints. The commissioner’s office will typically relay the complaint to the insurer and request a response by a certain date. If the insurer’s response is unsatisfactory, the commissioner may direct a course of action.

**The Role of the NAIC**
The National Association of Insurance Commissioners (NAIC), established in 1871, is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories.

The NAIC functions as an advisory body and service provider for state insurance departments although without legal authority as a group, it imposes a strong influence in the area of the industry’s self-regulation. The NAIC is the organization that has done the most to standardize law between the states. Although the wording, and sometimes the provisions themselves differ from state to state, for the most part the differences are only slight as each state attempts to follow, in essence, the wording of the “model laws” established by the NAIC.

**NAIC Model Laws**

The NAIC generally meets quarterly to conduct its affairs. Activities are conducted through committees, subcommittees, task forces and working groups staffed by state insurance regulators and their staffs with final action taken by the NAIC members as a whole. The NAIC has its own staff that supports the activities of the state insurance regulators. A listing of committees and committee charges (current assignments) together with information on current activities is available on the website of the NAIC – www.naic.org (select “Committees and Activities”). The NAIC publishes minutes of its meetings in the form of the NAIC Proceedings, which are available for purchase from the NAIC.

One of the key activities of the NAIC is the adoption of model laws and regulations, and amendments thereto. These model laws and are recommended for each state to enact (through their state legislatures) or promulgate (as regulations to the extent they may be promulgated by a state insurance regulator).

The NAIC publishes a multiple-volume set of model laws and regulations titled “Model Laws, Regulations and Guidelines” which collects all current model laws and regulations. Each model law or regulation includes:

- The text of the model law or regulation together with its history (citing to the NAIC Proceedings),
- A listing of states that have enacted the model or a related law, and its citation, and
- Usually a history of the model law or regulation prepared by the NAIC staff.

To review a list of the NAIC Model Laws, regulations and guidelines you can go to: http://www.naic.org/documents/committees_models_table_of_contents.pdf

**The Purpose and Structure of Insurance Regulation**
The fundamental reason for government regulation of insurance is to protect American consumers. Insurance is more heavily regulated than other types of business because of the complexity of the insurance contracts, the lack of sufficient information for insurance consumers to adequately shop for prices and adequacy of coverage and because insurance contracts are generally contracts of adhesion. Conceptually insurance regulation is very simple. The public wants two things from insurance regulators. They want solvent insurers who are financially able to make good on the promises they have made and they want insurers to treat policyholders and claimants fairly. All regulatory functions will fall under either solvency regulation or market regulation to meet these two objectives. State insurance regulatory systems are accessible and accountable to the public and sensitive to local social and economic conditions. State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept. Insurance regulation is structured around several key functions, including insurer licensing, producer licensing, product regulation, market conduct, financial regulation and consumer services.

Let’s review each of these key functions in greater detail.

**Insurer Licensing**

State laws require insurers and insurance-related businesses to be licensed before selling their products or services. Currently, there are approximately 7,800 insurers in the United States. All U.S. insurers are subject to regulation in their state of domicile and in the other states where they are licensed to sell insurance. Insurers who fail to comply with regulatory requirements are subject to license suspension or revocation, and states may exact fines for regulatory violations. In 2010, there were 342 companies that had their licenses suspended or revoked. The NAIC’s Uniform Certificate of Authority Application (UCAA), an insurer licensing facilitation system, helps states expedite the review process of a new company license. In addition, an NAIC database has been developed to facilitate information sharing on acquisition and merger filings. These databases assist insurance regulators by creating a streamlined and more cost efficient regulatory process.

**Producer Licensing**

Insurance agents and brokers, also known as producers, must be licensed to sell insurance and must comply with various state laws and regulations governing their activities. Currently, more than two million individuals are licensed to provide insurance services in the United States. State insurance departments oversee producer activities in order to protect insurance consumer interests in insurance transactions.

The states administer continuing education programs to ensure that agents meet high professional standards. Producers who fail to comply with regulatory requirements are subject to fines and license suspension or revocation. In 2010, roughly 5,000 insurance producers had their licenses suspended or revoked. Fines exceeded $25 million and over $50 million was returned to rightful owners. When insurance producers operate in multiple jurisdictions, states must coordinate their efforts to track producers and prevent
violations. Special databases are maintained by the NAIC to assist the states in this effort. The National Insurance Producer Registry (NIPR)—a non-profit affiliate of the NAIC—was established to develop and operate a national repository for producer licensing information.

**Product Regulation**

State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of the regulatory reviews of rates, rating rules and policy forms varies somewhat among the states depending on their laws and regulations.

For personal property-casualty lines, about half of the states require insurers to file rates and to receive prior approval before rate or policy form filings go into effect. With the exception of workers’ compensation and medical malpractice, commercial property-casualty lines in many states are subject to a competitive rating approach. Under such a system, regulators typically retain authority to disapprove rates if they find that competition is not working.

Rates for life insurance and annuity products generally are not subject to regulatory approval, although regulators may seek to ensure that policy benefits are commensurate with the premiums charged.

Historically, many states subjected health insurance rates to prior approval—with some states using a “file and use” system or no provisions for review. The recently adopted Affordable Care Act has changed the landscape for health insurance. All states now must review health insurance rates before they go into effect. Health insurance rates are also subject to review by the Department of Health and Human Services if the rate change is deemed to be “unreasonable.” Improvements are also included addressing the way in which consumers shop for health insurance. Health insurance exchanges are being developed and there is much focus of transparency of consumer information.

State insurance regulators, in the early 1990s, developed SERFF (System for Electronic Rate and Form Filings). The intent was to provide a cost-effective method for handling insurance policy rate and form filings between regulators and insurance companies. The SERFF system is designed to enable companies to send and states to receive, comment on, and approve or reject insurance industry rate and form filings. It has added incredible operational efficiencies that enhanced speed to market for rate and policy form filings. Today, there are currently 31 states that have made it official—they want to SERFF or file electronically (see Table 3.2).

| Table 3.2 |
| State SERF Mandate |

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Insurance regulators have also been innovative in addressing speed to market concerns of insurers desiring the ability to make a single filing that applies in multiple jurisdictions. The Interstate Insurance product Regulation Compact (Compact) is an important modernization initiative that benefits state insurance regulators, consumers and the insurance industry. The Compact enhances the efficiency and effectiveness of the way insurance products are filed, reviewed and approved allowing consumers to have faster access to competitive insurance products in an ever-changing marketplace. The Compact promotes uniformity through application of national product standards embedded with strong consumer protections.

The Compact established a multi-state public entity, the Interstate Insurance Product Regulation Commission (IIPRC) which serves as an instrumentality of the Member States. The IIPRC serves as a central point of electronic filing for certain insurance products, including life insurance, annuities, disability income and long-term care insurance to develop uniform product standards, affording a high level of protection to purchasers of asset protection insurance products. The IIPRC uses the SERFF filing network for its communications between the 44 participating jurisdictions (43 states and Puerto Rico), representing approximately two-thirds of the premium volume nationwide, and the insurers using the system for filings.

Financial Regulation

Financial regulation provides crucial safeguards for America’s insurance consumers. The states maintain at the NAIC the world’s largest insurance financial database, which provides a 15- year history of annual and quarterly filings on 5,200 insurance companies. Periodic financial examinations occur on a scheduled basis. State financial examiners investigate an insurer’s accounting methods, procedures and financial statement presentation. These exams verify and validate what is presented in the insurer’s annual statement to ascertain whether the insurer is in sound financial standing. When an examination of financial records shows the company to be financially impaired, the state insurance department takes control of the insurer. Aggressively working with financially troubled companies is a critical part of the regulator’s role. In the event the insurer must be liquidated or becomes insolvent, the states maintain a system of financial guaranty funds that cover most of consumers’ losses.

State financial regulators are subject to a peer review through an accreditation process. To achieve accreditation, an insurance department is required to undergo a
comprehensive review by an independent review team every five years to ensure the department continues to meet baseline financial solvency oversight standards. The accreditation standards require state insurance departments to have adequate statutory and administrative authority to regulate an insurer's corporate and financial affairs, as well as the necessary talent and resources to carry out that authority.

**Market Regulation**

Market regulation attempts to ensure consumers are charged fair and reasonable insurance prices, have access to beneficial and compliant insurance products and insurers operate in ways that are legal and fair to consumers. With improved cooperation among states and uniform market conduct examinations where uniformity is needed, regulators hope to ensure continued quality consumer protection at the state level. Traditional market conduct examinations occur on a routine basis, but also can be triggered by complaints against an insurer. These exams review producer licensing issues, complaints, types of products sold by insurers and producers, producer sales practices, compliance with filed rating plans, claims handling and other market-related aspects of an insurer’s operation. When violations are found, the insurance department makes recommendations to improve the insurer’s operations and to bring the company into compliance with state law. In addition, an insurer or insurance producer may be subject to civil penalties or license suspension or revocation.

Insurance regulators, through the NAIC, began the Market Conduct Annual Statement (MCAS) in 2002 with the goal of collecting uniform market conduct related data. The MCAS provides market regulators with information not otherwise available for their market analysis initiatives. It promotes uniform analysis by applying consistent measurements and comparisons between insurers. MCAS has always been a collaboration of regulators, industry and consumers who recognize the benefits of monitoring, benchmarking, analyzing, and regulating the market conduct of insurance companies. Through this teamwork, MCAS has grown from eight states collecting only Life and Annuity information to nearly all states collecting Property and Casualty data, as well as Life and Annuity information.

**Consumer Services**

The single most significant challenge for state insurance regulators is to be vigilant in the protection of consumers, especially in light of the changes taking place in the financial services marketplace. State insurance regulators have established toll-free hotlines, Internet Web sites and special consumer services units to receive and handle complaints against insurers and insurance producers. The state insurance regulators also have launched an interactive tool to allow consumers to research company complaint and financial data using the NAIC Web site. Called the Consumer Information Source (at https://eapps.naic.org/cis/), this web-based tool allows consumers to file a complaint, report suspected fraud and access key financial and market regulatory information about insurers.
During 2010 (latest data available), state insurance departments handled over 2.1 million consumer inquiries and over 300,000 formal consumer complaints. As needed, state insurance departments worked together with claimants, policyholders and insurers to resolve disputes. In addition, many states sponsor consumer education seminars and provide consumer brochures on a variety of insurance topics. Many states publish rate comparison guides to help consumers get the best value when they purchase insurance.

**Federal Legislation**

Below are several pieces of federal regulations that have been passed to protect consumers when purchasing insurance.


The Employee Retirement Income Security Act (29 U.S.C. Section 1001 seq.), also known as ERISA, passed by Congress and signed into law by President Gerald Ford back in 1974, is a complex body of federal statutory law that, in general, deals with matters relating to both employee pension benefit plans and employer sponsored health and welfare benefit plans.

The purpose of ERISA was to set consistent nationwide standards of protection for employer pension, health care and other employee benefit plans from mismanagement and fraud.

**Fair Crediting Reporting Act**

In 1970, the federal government passed the Fair Credit Reporting Act, or FCRA, with the intent of protecting individual’s right to privacy. When an application is submitted to a life or health insurance company, a consumer reporting agency is hired to obtain personal information about the applicant to be used in the underwriting evaluation. FCRA established procedures for the collection and disclosure of information obtained on consumers through investigation and credit reports; it seeks to ensure fairness with regard to confidentiality, accuracy and disclosure. The FCRA is quite extensive. Included in it are the following important requirements pertaining to insurers:

- Applicants must be notified (usually within three days) that the report has been requested. The insurer must also notify the applicant that he or she can request disclosure of the nature and scope of the investigation. If the applicant requests such disclosure, the insurer must provide a summary within five days of the request.
- The consumer must be provided with the names of all people contacted during the preceding six months for purposes of the report. People contacted who are associated with the consumer’s place of employment must be identified as far back as two years.
• If, based on inspection or consumer report, the insurance rejects an application; the company must provide the applicant with the name and address of the consumer reporting agency that supplied the report.

• If requested by the applicant, the consumer reporting agency—not the insurance company—must disclose the nature and substance of all information (except medical) contained in the consumer’s file. Note that the file may be more extensive than the actual report that was provided to the insurer. The Fair Crediting Reporting Act does not give consumers the right to see the actual report, although most reporting agencies do routinely provide copies of the report, if requested.

• If the applicant disagrees with information in the file, he or she can file a statement giving his or her opinion on the issue.

**HIPAA**

As financial advisors with life and health licenses, we are exposed to and trusted with personal medical information from the clients we work with. It has always been good business practice to view this type of information as confidential. In 1996, however, the federal government passed *The Health Insurance Portability and Accountability Act* (HIPAA), which provides specific rules for how an insurance producers/financial advisors must protect personal medical information.

Who is required to comply with HIPAA?

• **Covered Entities** – A Covered Entity includes health plans, health care clearinghouses and most health care providers. (Includes employer group health plans)

• **Business Associates** – A Business Associate includes a business or an individual who works with a Covered Entity and creates, uses, receives or discloses protected health information.

• **Employer and Other Sponsors of Group Health Plans** – Includes all employers that receive protected health information as well as other organizations that sponsor group health plans, e.g., a union plan.

HIPAA defines as any individually identifiable health information that is created or received by a health care provider, health plan, employer or health care clearinghouse. (PHI includes a person’s name and address.) HIPAA requires that a group health plan does not disclose this information except for the following permitted or required disclosures:

• To the individual.

• To carry out treatment, payment or health care operations.

• With a valid authorization.

• Under limited circumstances, when the individual has the opportunity to agree or object to the use or disclosure.

• For defined “public good function” and for very limited “marketing” purposes.
Disclosure of protected health information to business associates, with satisfactory assurance that the business associate will adequately safeguard the information.

Required Disclosures

- To individuals seeking to access their protected information.
- To individuals seeking an accounting of disclosures of their protected health information.
- When required by the secretary of HHS to investigate or determine the health plan’s compliance with the regulation.

Business Associates – as life and health agents, we fall under the definition of a “Business Associate,” consequently, we are required to enter into a “BA” contract with the health plans with which we work. These contracts are required to have the following provisions:

- Establish the permitted uses and disclosures of protected health information.
- Provide that the business associate will not use or further disclose the information other than as allowed under the contract or required by law.
- Provide that the business associate will use appropriate safeguards to prevent the unauthorized disclosure of information.
- Require the business associate to report to the health plan any unauthorized uses or disclosures of the information.
- Ensure that agents or subcontractors to whom the business associate discloses protected health information agree to these same restrictions.
- Provide that the business associate will make protected health information available for inspection.
- Establish the permitted uses and disclosures of protected health information.
- Provide that the business associate will not use or further disclose the information other than as allowed under the contract or required by law.
- Provide that the business associate will use appropriate safeguards to prevent the unauthorized disclosure of information.
- Establish the permitted uses and disclosures of protected health information.
- Provide that the business associate will not use or further disclose the information other than as allowed under the contract or required by law.
- Provide that the business associate will use appropriate safeguards to prevent the unauthorized disclosure of information.

The Financial Services Modernization Act of 1999

The Financial Services Modernization Act of 1999, also known as the Gramm-Leach-Bliley Act, established a comprehensive regulatory framework to permit affiliations among banks, securities firms and insurance companies by repealing the Depression Era Glass-Steagall Act. The Gramm-Leach-Bliley Act once again affirmed that states should
regulate the business of insurance by declaring that the McCarran-Ferguson Act remained in effect. However, Congress also called for state reform to allow insurance companies to compete more effectively in the newly integrated financial service marketplace and to respond with innovation and flexibility to evermore demanding consumer needs. It established the concept of functional regulation where each functional regulator is responsible for regulation of its functional area.

The Wall Street Reform and Consumer Protection Act of 2010

The Wall Street Reform and Consumer Protection Act of 2010, better known as the Dodd-Frank Wall Street Reform Act once again had an impact on state insurance regulation. While primarily banking and securities reform legislation, Dodd-Frank did create the Federal Insurance Office (FIO) under Title V, Section 502, as an information gatherer to inform Congress on insurance matters. In addition, under Title IX; Section 989J of the Act (also known as the Harkin Amendment), it contains a provision that limits the ability of the U.S. Securities Exchange Commission (SEC) to classify indexed annuities and other insurance products as securities.

The provision states that an insurance product, annuity product or endowment product with a value that does not vary according to the performance of a separate account is an insurance product, as long as the product meets or exceeds nonforfeiture and suitability criteria set by the NAIC.

Starting in 2013, a product eligible for Section 989J protection must be issued by an insurer in a state of domicile that adopts any new NAIC suitability rules within 5 years of the rules being established.

To review the whole document of the Act visit: www.sec.gov/about/laws/wallstreetreform-cpa.pdf

The Future of Insurance Regulation

While states dominate the regulation of insurance industry, since the great recession of 2008-2009, with the federal bailout of one of America’s largest insurance conglomerates along with the failure of a host of its bond insurers, there has been an increase of concerns that the insurance industry is not necessarily a stable, staid keeper of our rainy day funds. It is important to remember that today, insurance is a global business, with huge firms writing not just life and home insurance policies, but also entering into more exotic lines of business. Most notoriously, the industry regularly uses credit default swaps, which have proved to be capable of exposing those firms to the vicissitudes of international finance and the risk of insolvency.

But the American insurance regulation system has long been focused on the local market and the protection of policy holders, instead of the global market and the stability of
insurance firms. To the extent that state insurance commissioners focus on the solvency of insurers, they do so from a consumer protection perspective. That means they consider whether firms are likely to be able to pay out on their policies, rather than on the effect that they have on the financial system as a whole.

Some financial experts claim that the financial crisis shows that American insurance supervision is focused on the wrong problems. In fact, under Section 313(p) of Title 31 of the United States Code, as codified by the Dodd-Frank Wall Street Reform and Consumer Protection Act, it required the Federal Insurance Office to conduct a study on how to modernize and improve the system of insurance regulation in the United States.

After nearly two years of delay, the U.S. Department of the Treasury’s Federal Insurance Office (FIO) released its report, on how to modernize and improve the system of insurance regulation in the United States. The FIO report concluded that in some circumstances, policy goals of uniformity, efficiency, and consumer protection make continued federal involvement necessary to improve insurance regulation. The report states:

“...should the states fail to accomplish necessary modernization reforms in the near term, Congress should strongly consider direct federal involvement.”

However, in a softer note the report emphasizes that insurance regulation in the United States is best left to a hybrid mode, where both state and federal regulatory bodies play complementary roles.

“The business of insurance involves offering many products that are tailored for and delivered at a local level. For the most part, effective delivery of the product will require local knowledge and relationships, and local regulation. Moreover, establishing a new federal agency to regulate all or a part of the $7.3 trillion insurance sector would be a significant undertaken.”


Certainly the future role of states in the insurance regulatory arena is in question. There is no doubt that there are serious barriers to coordination among the states which prohibit them from being effective regulators on certain issues. In addition, because of the predominance of nationwide operations, there are potential externalities that can be remedied by a federal approach to regulation (like CE and state licensing requirements). To be fair, there are also potential problems with federal regulation that need to be addressed. State regulation does protect the industry from bad regulation in the sense that if a state were to make a serious error regarding regulation, the negative effects of the error will likely be most felt in the state with the “bad” regulation. In contrast, a mistake
at the federal level hurts the entire industry nationwide. Further, merely copying state regulation without thinking about the merits of the regulation is also inefficient.

So, whatever your feelings are with regards to the regulation of insurance industry it will probably continue on the current path of a “hybrid” approach consisting of both state and federal regulation. Stay tuned!
Chapter 3
Review Questions

1. Which of the following court decisions held that insurance is not commerce and is therefore not subject to regulation by the federal government?
   ( ) A. Paul v. Virginia
   ( ) B. United States v. South-Eastern Underwriters Assoc.
   ( ) C. Prudential Ins. Co. v. Benjamin
   ( ) D. None of the above

2. Most regulation of the insurance industry is conducted at what level?
   ( ) A. Federal
   ( ) B. State
   ( ) C. Self-regulation
   ( ) D. NAIC

3. The body of laws regulating the insurance industry at the state level is called:
   ( ) A. State statutes
   ( ) B. Administrative Rules
   ( ) C. Insurance Code
   ( ) D. State Constitution

4. Which of the following Acts enacted by Congress provides specific rules for how an insurance producers/financial advisors must protect personal medical information?
   ( ) A. The Fair Crediting Reporting Act of 1970
   ( ) B. The Dodd Frank Wall Street Reform Act of 2010
   ( ) C. The Employee Retirement Income Security Act of 1974
   ( ) D. The Health Insurance Portability and Accountability Act of 1996

5. Which Section of the Dodd-Frank Wall Street Reform Act contains a provision that limits the ability of the SEC to classify indexed annuities and other insurance products as securities?
   ( ) A. Section 152
   ( ) B. Section 502
   ( ) C. Section 412
   ( ) D. Section 989J
CHAPTER 4

UNFAIR TRADE PRACTICES

Overview

All states have laws that prohibit insurers from engaging in “unfair trade practices.” The NAIC Unfair Trade practices Act was one of the first NAIC model laws, having been adopted in 1947 shortly after enactment of the McCarran-Ferguson Act in 1945.

In this chapter, we will examine several unfair trade practices that have been developed by the NAIC in their enforcement of ethical practices in the insurance industry. It will also review several other Model laws issued by the NAIC that have become part of many state’s insurance code to protect consumers from unfair marketing practices conducted by unethical insurance producers. In addition, the chapter will also review the FINRA/SEC suitability laws.

Learning Objectives

Upon completions of this chapter, you will be able to:

- Demonstrate an understanding of the Unfair Marketing Practices;
- Identify when to use and not to use specific Certifications and Designations;
- Recognize the key elements of the Annuity Disclosure Rules;
- Demonstrate when a sale of an annuity may be unsuitable;
- Apply the 2010 Annuity Suitability Model Regulation in the sale of annuities; and
- Identify the FINRA/SEC suitability rules.

Background

Each state regulates the ethical conduct of insurance producers by creating rules, regulations and legislation (statutes) that become part of the state’s Insurance Code that is set forth to protect the consumer.

The Unfair Marketing Practices Act was created by the National Association of Insurance Commissioners (NAIC) back in the 1940’s and since then has been amended (2004) and expanded. The Act is divided into two parts—Unfair Marketing Practices and Unfair Claims Practices. In each state, statutes define and prohibit certain marketing practices and claims practices, which are unfair, unethical, misleading and deceptive.

The purpose of this Act:
“... is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress) and the Gramm-Leach-Bliley Act (Public Law 106-102, 106th Congress), by defining or providing for the determination of, all such practices in this state that constitute unfair methods of completion or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. Nothing herein shall be construed to create or imply a private cause of action for a violation of this Act.”

Unfair Marketing Practices

Below are several of the Unfair Marketing Practices which is a section of Unfair Trade Practices Act that insurance producers should avoid.

Misrepresentation

“Misrepresentation” is simply a false statement of fact; that is a lie. For many insurance agents, the biggest market conduct danger they may face is making a misrepresentation during a sales presentation. Sometimes, it is the result of over-enthusiasm of “selling” the benefits of a policy too strongly. It may also be the result of a willingness to stretch the advantages of a particular product and sidestep the disadvantages. While on the other hand, providing vague or elusive responses is just as serious a form of misrepresentation as is deliberately lying about a policy’s features and benefits or expected performance.

Fraud

If an insurance agent intentionally misrepresents any information in an insurance transaction, he or she is guilty of “fraud.” An insurance agent found guilty of fraud may be subject to fines and/or imprisonment as well as the possible loss of their license to sell insurance as well as public disgrace.

Altering Applications

“Altering applications”, for any purpose, is not permitted. It is illegal and insurance agents must not engage in altering applications.

In the past, applications have been altered for a number of fraudulent reasons, such as to:

- Change underwriting information to get a more favorable premium rate, or
- Switch the type of coverage applied for, or
- Add additional zeroes to the amount of coverage applied for.
**Premium Theft**

Of all the prohibited activities, “premium theft” ranks among the worst offense an insurance agent can commit. In addition to the outright theft of the premium money, failure to turn over a premium on a policy prevents the policy from going into effect. The consumer believes he or she is insured, but in fact, the application was never submitted to the insurance company. These situations are quickly discovered if any inquiry is made by the prospective insured or the insurance company.

Premium theft is rigorously punished by every state Insurance Department.

**False or Misleading Advertising**

The potential for “false (deceptive) advertising” or promotion by insurance companies and or insurance agents alike is significant and the consequences to the consumer can be grave. Accordingly, all states regulate insurance advertising.

The NAIC has created a model regulation more specifically directed at advertising—the Rules Governing Advertising of Life Insurance. This model regulation, which so far has been adopted by more than 31 states, defines advertising and attempts to address those actions that have caused the most problems in the industry. It also mandates the proper identification of insurance agents and companies, a system of control over its advertisement, a description of the type of policy advertised, and the disclosure of graded or modified benefits over time and so forth.

Recently, several states have passed specific legislation (For example in California, two bills were passed by the legislators, SB 620 and SB 618) for regulating advertising to seniors age 65 and older.

**Defamation**

“Defamation” is any false maliciously critical or derogatory communication written or oral—that injures another’s reputation, fame or character. Without the element of communication there can be no defamation. Both insurance agents and insurers can be defamed. Unethical insurance agents participate in defamation by spreading rumors or falsehoods about the character of a competing insurance agent or the financial condition of another insurer.

**Boycott, Coercion, Intimidation**

“Boycott, coercion and intimidation” are unethical trade practices, which attempt to limit or restrain trade in the sale of insurance. No person or company has the right or the power to force, coerce or intimidate any person into purchasing insurance from a specific insurance agent or insurer.
Twisting

“Twisting” is the unethical act of inducing a client to lapse, surrender or terminate an existing insurance product solely for the purpose of selling another policy with another insurer without regard to the possible disadvantages to the policy owner. By definition, twisting involves some kind of misrepresentation by the insurance agent to convince the policy owner to switch insurers. The key word in the definition of “twisting” is “inducement”. Twisting is illegal and should not be confused with replacement, which is legal if done in accordance with specific state laws.

Churning

Related to twisting is “churning”. If an insurance agent induces a prospect/client to replace a policy with a new policy with the same insurer and if the replacement is not in the client’s best interest, the insurance agent is guilty of churning. In cases involving churning, there is no demonstrated benefit to the policy owner with the new policy or contract. Churning is unethical and illegal.

Discrimination

“Discrimination” is both illegal and unethical in accordance with state and federal laws. From an insurer’s perspective, it is unlawful to permit discrimination between individuals of the same class and life expectancy regarding life insurance rates, dividends or other policy benefits. It is unlawful to discriminate because of age in the issuance of and rates for automobile insurance. It is unethical and illegal to permit or cause discrimination due to race, creed, color or national origin regarding the issuance or the rates charged for insurance.

Rebating

Splitting a commission or paying a client for his or her business is considered “rebating.” Rebating occurs if the buyer of an insurance policy receives any part of the insurance agent's commission or anything else of significant value as an inducement to purchase the insurance product being sold by the insurance agent. Rebating is illegal in all but two states:

- California (Rules regarding unfair practices are outlined in CA Assembly Bill 689 specific to annuity sales and suitability to seniors, and in CIC 790-790.15 for all insurance transactions); and
- Florida (Rules specific to the allowance of rebating are found in the 2012 Florida Statues, Title XXXVII, Section 626.572).

However, most insurers forbid their insurance agents to rebate even in jurisdictions where it is legal. It is acceptable to provide gifts of nominal value (pens, calendars, coffee mugs, etc.) to prospects and clients when those gifts are given regardless of whether or not you
make a sale. If you provide a nominal gift, you must provide it to everyone you approach.

**Use of Senior Specific Certifications and Designations**

The NAIC membership gave its final approval (Fall Meeting-September 2008) on the Model Regulation on the Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities (Model Regulation 278). The new model follows the approach for regulating senior-specific designations taken in the model rule adopted on April 1, 2008 by the North American Securities Administrators Association (NASDSA).

Both models are designed to stop the use of misleading senior-specific designations by establishing a standard of whether the use of a particular designation indicates or implies, in a way that misleads the consumer, that the agent has special certification or training in advising seniors. Neither model references specific designations; rather, individual designations will be measured against this standard. The models establish what is essentially a safe harbor for designations that:

- Are not primarily sales/marketing oriented and
- Are issued/accredited by the American National Standards Institute, the National Commission for Certifying Agencies, or an institution of higher education.

The models also expressly prohibit the use of designations that have not been legitimately earned, that are nonexistent, or that misrepresent a level of expertise of education that does not exist.

The NAIC Model applies to the sale of insurance-related products. Under Section 5 A(1) of the Model Act it states:

> “It is unfair and deceptive act of practice in the business of insurance for an insurance producer to use a senior-specific certification or professional designation that indicates or implies in such a way as to mislead a purchaser or prospective purchaser that insurance producer has special certification or training in advising or servicing seniors in connection with the solicitation, sale or purchase of a life insurance or annuity product or in the provision of advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product, either directly or indirectly through publications or writings, or by issuing or promulgating analyses or reports related to a life insurance or annuity product.”

The prohibited use of senior-specific certifications or professional designations includes, but is not limited to, the following:
• Use of a certification or professional designation by an insurance agent who has not actually earned or is otherwise ineligible to use such certification or designation;
• Use of a nonexistent or self-conferred certification or professional designation; use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training or experience that the insurance agent using the certification or designation does not have; and
• Use of a certification or professional designation that was obtained from a certifying or designating organization that:
  o Is primarily engaged in the business of instruction in sales or marketing;
  o Does not have reasonable standards or procedures for assuring the competency of its certificants or designees;
  o Does not have reasonable standards or procedures for monitoring and disciplining its certificants or designees for improper or unethical conduct; or
  o Does not have reasonable continuing education requirements for its certificants or designees in order to maintain the certificate or designation.

Go to http://www.naic.org/store/free/MDL-278.pdf to view the Model Regulation

**Ledger Selling**

A very important ethical issue all insurance producers will be faced with is presenting appropriately designed life insurance and annuity illustrations to their clients. In the past, policy illustrations were calculated and printed by the home office, now insurance producers can calculate and print illustrations from their personal computers and laptops in front of their clients.

This technology has led to many industry regulators voicing their concerns over the ethical issue of the prevalence of what they call “ledger selling”—making sales based primarily on the figures shown in a policy illustration. Let’s examine how “ledger selling” has led to a problem for the life insurance industry.

**Life Insurance Illustrations**

Since the 80’s many insurance producers have become very comfortable using policy illustrations as a way from getting away from the traditional life insurance sales process of identifying clients’ needs (needs selling) and then selling a product to meet those needs. In needs selling, the death benefit of the life insurance takes center stage, and cash value played a secondary role. Now, when presenting a life insurance illustration, the cash value column is usually as prominent as the death benefit. Prospects are naturally attracted to cash values more than death benefits, so a lot of life insurance sales began to be made on the basis of what the policy owner could do with those cash values (funds to supplement a retirement income plan, or paying for a child’s college education for example) rather than what the death benefits would do for the individual’s survivors.
How many times have you seen a life insurance illustration given to you by a client who asked you for a second opinion and you see circled or highlighted the cash values at age 65? What do you think the insurance producer is selling—the death benefit or the cash value?

Now don’t get me wrong there is nothing unethical about pointing out the living benefits of cash value life insurance. But, it must be done in conjunction with a discussion of the policy’s death benefit. What if prospects just do not want to hear about death benefits? What if the only way to get someone’s attention to purchase a life insurance policy is to emphasize cash values? The surviving dependents of such people will benefit from the life insurance proceeds, even if these clients themselves do not realize the extent of their need. Isn’t cash-value-based selling justified in such cases?

From an ethical standpoint, the answer is generally, no. Resorting to cash-value-based selling is usually just an excuse to avoid the professional work of convincing certain people that they need the death benefit that life insurance provides. Life insurance should only be sold if the client has a death benefit need first. Professional insurance producers must not fall in the trap of thinking that they can do what’s best for others by not disclosing pertinent information from them. As for who benefits from such sales, the party that receives the most immediate economic benefit is the insurance producer who earns the commission, followed closely by the insurer that receives the premium. This leaves the ethical burden on those two parties. If a producer is getting paid for any action, it will be perceived that the producer did it for the money, aside from any good intentions. So in any sales presentation involving illustrations, the professional insurance producer should make sure their behavior is strictly ethical.

Guaranteed Values vs. Non-guaranteed Values

In addition to needs selling, the professional insurance producer must make sure that he or she is accurately representing what the numbers in a life insurance policy illustration mean. A professional insurance producer won’t get into trouble if they illustrate only guaranteed values, and for this reason some producers in the life insurance industry feel that all policy illustrations should show only the guaranteed values. Other producers in the life insurance industry feel that there is a reasonable possibility that policies will earn amounts in excess of the guaranteed values shown, and that insurance producers and companies should continue to be able to illustrate that possibility, provided that consumers are made to understand clearly which values are and are not guaranteed. As a compromise, show both guaranteed values and current values, beginning with the guaranteed columns first, and after you fully disclose this information, then show the current values and its projections and fully disclose their possibilities.

Here’s where another ethical question comes to play. What can prospects truthfully be told about the non-guaranteed values shown in policy illustrations? On the one hand, the figures are based on a mathematical formula. If all the assumptions upon which the illustration is based hold, the policy will in fact pay the values shown. On the other hand, the illustration is based on so many different assumptions that it is highly likely that
actual experience will differ in at least one respect. That’s why I call life insurance illustrations “dream sheets.” It may not be correct to characterize the illustration of non-guaranteed values as meaningless, but at the same time those figures are not all certain. And also remember, do you ever see the non-guaranteed projections illustrated in the actual policy. No, only the guaranteed values can be illustrated in the contract (policy).

When you present a sales illustration, clearly explain to the prospect what each section and column means. Always tell your prospects and clients that portions of sales illustrations are projections, not guarantees, of how a contract will perform. You cannot overemphasize to them that illustrations contain projections based on current interest rates, current mortality charges, and other expenses. These conditions are not contractual obligations, therefore they are not guaranteed.

**Inappropriate Uses of Policy Illustrations**

As we discussed previously, policy illustrations are generally not useful for trying to provide estimates of the values a policy will provide. There are several reasons why that is true.

- **The many factors that come into play.** Policy performance is based on many factors and one or more of them is not going to actually behave the way it has been assumed it will in the policy illustrations. For the prospect to understand truly what the policy illustration is showing, a professional insurance producer would have to explain the relative effect of every factor upon which performance is based, and that would likely create more confusion than enlightenment. It may be better to simply say the figures are hypothetical, illustrative of concepts, not actual estimates of future performance.

- **The unpredictability of the factors.** There are three categories of factors that go into policy performance:
  - expenses
  - mortality, and
  - investment return

- **The long time periods involved.** In economics as in the weather, the farther ahead you try to look, the less likely it is that the details of any forecast will be correct. Experts disagree about the impact of current trends and how much longer they will continue. There’s certainly no way to predict what the trends will be 10, 20, or 50 years from now.

- **The human factor.** Remember that regardless of the company’s actual experience, the determination of exactly what gets passed on to policy owners is largely left to the discretion of company management. Decades from now, who knows who the company managers will be? No one could say for certain today how a given policy would perform even if they knew what the company’s investment, mortality, and expense experience was going to be.

With this much uncertainty, you can see why it’s essential that prospects understand which figures on a policy illustration are guaranteed and which ones are not. When
illustrating non-guaranteed values, it’s safest to do what most professional insurance producers would do: in addition to clearly disclosing which values are non-guaranteed, they also use conservative assumptions to project non-guaranteed values.

**Comparing Competing Proposals**

Probably the greatest pressure to misuse policy illustrations is in a competitive situation. When competition arrives on the scene, even a situation that began as a needs-based sale can end up with a misguided over-emphasis on illustrated benefits.

Such dependence occurs readily in competitive situations for the same reason that policy illustrations can mistakenly become an automatic part of every sale: the figures in the illustration lend the appearance of tangibility to an otherwise intangible product. The prospect seems to be on much firmer ground comparing two columns of figures than trying to determine which company or insurance producer has the best attitude toward service or is most interested in fair treatment of policy owners. In our culture, people are encouraged to be oriented to the “bottom line.” Prospects who don’t know any better feel completely comfortable basing their buying decisions on a comparison of policy illustrations.

In fact, as you should realize by now, policy illustrations provide little basis for comparing competing proposals. Any two illustrations are probably based on two different sets of assumptions. Even if the same assumptions were used, its actual experience that determines policy performance, and it’s very unlikely that two policies from different companies are going to reflect actual experience in the same way. Tangible as those columns of figure seem, there’s nothing solid at all about any figures that illustrate non-guaranteed values.

Even with regard to guaranteed values, since there’s some chance that actual experience will be better than the minimum assumed (although no one can say for certain whether that will occur or by how much), those figures aren’t reliable predictors of what the future will hold for the policy owner, either.

Guaranteed values provide a floor that the policy owner can count on, which is a benefit in and of itself. But in a competitive situation, which policy has the higher guaranteed amounts may not be the most important consideration if both policies may perform better than their guarantees.

When comparing policies there is much more to look at besides the policy illustration. Riders can be of particular significance in term of the benefits provided to the insured, but these benefits aren’t always clear in policy illustrations, nor are base policy provisions that may be more favorable to the insured in one policy or the other. Sometimes an illustration crediting a lower interest rate can illustrate better values than an illustration crediting a higher interest rate. The cause of the difference may be in other economic assumptions under which the two illustrations were run, or the difference may be in riders or other policy provisions. To help clients decide which policy may be the
best policy for them, insurance producers must have as complete a picture of the competing policy as they have of the policy they are proposing. A complete picture involves an analysis of more than just the policy illustrations. Remember, it’s difficult if not impossible to judge an orange against an apple.

NAIC Life Insurance Illustrations Model Regulation

The NAIC Model Regulation on Illustrations prescribes standards for using illustrations and requires certain disclosure. It applies to all individual and group life insurance plans except variable life, individual and group annuities, credit life, and life insurance policies with no illustrated death benefit over $10,000. The model regulation has been adopted by all of the states (you can access a copy of the Model regulation at: http://www.naic.org/store/free/MDL-582.pdf)

Under the regulation, insurers must decide whether or not they wish to use illustrations to market a given policy form. If so, an illustration must be provided no later than policy delivery. If not, use of illustrations is prohibited.

Illustrations must:

- Identify the insurer, the producer (if any), the insured, the underwriting classification, the type of policy, the initial death benefit, and any option selected for applying non-guaranteed elements such as dividends.
- Be complete, accurate, clearly labeled, and presented in a truthful manner.
- Use an “illustrated scale” for non-guaranteed elements that is not more favorable than: 1) the current payable scale, or 2) a “disciplined current” scale certified by an actuary as being reasonably based on actual recent historical experience.
- Include both a narrative explanation and a numeric summary that shows values at policy years 5, 10, 20 and at age 70 on three different bases: 1) policy guarantees, 2) the illustrated scale, and 3) midway between the guarantees and the illustrated scale.

Insurers must retain a copy of an illustration for an issued policy until three years after the policy is no longer in force.

Illustrations for Fixed and Index Annuities

Over the past several years the use of illustrations with fixed annuities has been growing and some of the documents I would say are “pretty unrealistic.” Some industry groups have complained about inconsistencies, as have state regulators. This has certainly gone to the attention of the NAIC which created the NAIC Annuity Disclosure Working Group to look into the matter.

The new illustration provisions appears in Section 6 of the updated NAIC Annuity Disclosure Rule (January 2014) model (discussed below). This section sets standards for carriers that offer fixed and indexed annuity illustrations.
But insurance producers will need to know some things about the regulation if their state adopts the proposed new Annuity Disclosure model. Note: The proposed regulations that have resulted do not affect illustrations for variable annuity products. Those illustrations are already subject to regulation—by the Financial Industry Regulatory Authority (FINRA).

First, insurance producers should know that the illustrations won’t necessarily show how the product values will end up—not even close. In the case of fixed indexed annuities, they will show how the product works in different scenarios, such as good markets and bad markets.”

Second, for traditional fixed annuities, the illustrations would be required to show current rates. So you can’t illustrate interest rates other than what the insurance company is currently offering for the product. You can’t go higher and you can’t use wild assumptions.

The revised model would impact insurance producers in another way, as well. If an insurance producer is presenting a traditional fixed annuity or a fixed indexed annuity, you would be required to give the customer the following:

- A buyer’s guide for annuities,
- The disclosure document for the product, and
- The illustration if the carrier offers one.”

It is important to note that not all carriers offer fixed or indexed annuity illustrations. It’s entirely voluntary. But if the company does provide one, the insurance producer must present it with the other two documents. It’s a package deal.”

**NAIC Annuity Disclosure Model Regulation**

The purpose of this regulation is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. The regulation specifies the minimum information which must be disclosed, the method for disclosing it and the use and content of illustrations, if used, in connection with the sale of annuity contracts. The goal of this regulation is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts. To view the full document go to: [http://www.naic.org/store/free/MDL-245.pdf](http://www.naic.org/store/free/MDL-245.pdf).

**Applicability of Annuity Disclosure Regulation**

This annuity disclosure regulation applies to all group and individual annuity contracts and certificates except:

- Registered or non-registered variable annuities or other registered products;
• Immediate and deferred annuities that contain no nonguaranteed elements;
• Annuities used to fund plans or arrangements:
  o Annuities used to fund:
    ▪ An employee pension plan covered by the ERISA;
    ▪ A plan described by Sections 401(a), 401(k), or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;
    ▪ A governmental or church plan defined in Section 414 or a deferred compensation plan of a state or local government or a tax-exempt organization under Section 457 of the Internal Revenue Code; or
    ▪ A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.
  o Notwithstanding the first bullet above, this regulation applies to annuities used to fund a plan or arrangement:
    ▪ Funded solely by contributions that an employee elects to make whether on a pretax or after-tax basis; and
    ▪ Where the insurer has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an employee by a producer for the purchase of an annuity contract. Direct solicitation does not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;
    ▪ Structured settlement annuities.
    ▪ Charitable gift annuities.
    ▪ Funding agreements.

**Disclosure Document and Buyer’s Guide**

If a prospect takes an application for an annuity contract after meeting face-to-face with an insurer or a producer about annuities, the insurer or producer must give the prospect, at or prior to application, both the disclosure document and the Buyer’s Guide. If the prospect takes the application for an annuity contract other than in a face-to-face meeting with the insurer or producer, the insurer or producer must send the applicant both the disclosure document and the Buyer’s Guide no later than five (5) business days after the insurer receives the completed application.

**Insurer receives application through the Internet.** An insurer taking reasonable steps to make the Buyer’s Guide and disclosure document available for viewing and printing on the insurer’s Website satisfies the requirement that the Buyer’s Guide and disclosure document be provided to the prospect no later than five business days after the insurer receives the application.

Insurer receives application from direct solicitation through the mail. Providing a Buyer’s Guide and disclosure document in a mailing that invites prospects to apply for an annuity contract satisfies the requirement that the Buyer’s Guide and disclosure document be
provided to the prospect no later than five business days after the insurer receives the application.

A solicitation for an annuity contract in other than a face-to-face meeting must include a statement that the prospect may contact the state insurance department to receive a free annuity Buyer’s Guide. In lieu of such a statement, an insurer may include a statement that the prospect may contact the insurer to receive a free annuity Buyer’s Guide.

**Free-Look Period**

If an insurer or a producer fails to provide the disclosure document and annuity Buyer’s Guide to a prospect at or prior to application, the prospect must be given a free-look period of no less than 15 days, during which the annuity contract may be returned without penalty. Such free-look must run concurrently with any other free-look provided under state law or regulation.

**Minimum Required Information in Disclosure Document**

An insurer must define terms in the disclosure statement with easy-to-understand language for the average person within the segment of the population for which the disclosure statement is intended.

The following must, at a minimum, be included in an annuity disclosure document provided to prospects:

- The generic name of the contract, company product name, if different, and form number, and the fact that it is an annuity
- The insurer’s name and address
- A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate
  - guaranteed, non-guaranteed, and determinable elements of the contract, and their limitations, if any, and an explanation of how they operate
  - explanation of initial crediting rate, specifying any bonus or introductory portion, duration of the rate, and the fact that rates may change from time to time and are not guaranteed
  - periodic income options, both on a guaranteed and a nonguaranteed basis
  - any value reductions caused by withdrawals from, or surrender of, the contract
  - how values in the contract can be accessed
  - death benefit, if available, and how it will be calculated
  - summary of federal tax status of the contract and any penalties applicable on withdrawal of values from the contract
  - impact of any rider, such as a long-term care rider
- Specific dollar amount or percentage charges and fees must be provided, with an explanation of how they apply
• Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change

Report to Annuity Owners

For annuities in the payout period with changes in nonguaranteed elements and for a deferred annuity’s accumulation period, an insurer must provide each annuity owner with a report, at least annually, about the status of the owner’s annuity. The report must contain at least the following information:

• Beginning and end date of the current report period
• Accumulation and cash surrender value, if any, at the end of both the previous report period and the current report period
• Total amounts, if any, that have been credited, charged to the contract value, or paid during the current report period
• Outstanding loan amounts, if any, as of the end of the current report period

Penalties

In addition to any other penalties provided by a state’s laws, an insurer or producer that violates a requirement of this regulation will be guilty of a violation of the state’s unfair trade practices act.

Variable and MVA Annuities

The current version of the Disclosure Model applies to fixed, fixed indexed, and variable annuities (except for non-registered variable annuities issued exclusively to accredited investors or qualified purchasers), while the previous version applied only to fixed and fixed indexed annuities.

For variable annuities, the disclosure document requirement will apply after January 1, 2014, unless and until the SEC adopts a summary prospectus rule or FINRA approves for use a simplified disclosure form applicable to variable annuities. If the insurance producer is offering a variable annuity, the insurance producer would have to give the customer a buyer’s guide for annuities, in addition to the prospectus required by the Securities and Exchange Commission (SEC) and the illustration required by FINRA.

In other proposed revisions, the disclosure model would include a definition of market value adjusted annuity. It is the same definition as appears in the Interstate Insurance Producer Regulation Commission, “because it’s pretty much accepted by everybody,” Mumford says. The definition says:

“Market Value Adjustment or MVA feature is a positive or negative adjustment that may be applied to the account value and/or cash value of the annuity upon withdrawal, surrender, or death benefit payment or contract annuitization based on either the movement of an index or on the company’s current guaranteed
Also, the disclosure section of the proposed version says that, if the SEC has not completed developing a summary prospectus by Jan. 1, 2014, the disclosure requirements in the NAIC model would apply to variable annuities.

Note: The disclosure model is not the same as the NAIC’s Suitability In Annuity Transactions Model Regulation, most recently updated in 2010. The suitability model regulates pre-sale requirements for carriers and advisors, to ensure that what they are selling to the customer is suitable for that customer. The disclosure model regulates disclosure to the customer. Its purpose is to “ensure that customers have all the information they need to be sure what they buying what they think they are buying.”

**NAIC Life Insurance and Annuity Replacement Model Regulation**

Insurance producers often face replacement decisions. Replace a life, health, disability income, or annuity contract only when you know all the facts and have disclosed sufficient information to the client to allow him or her to determine whether the replacement is suitable.

As a professional insurance producer you cannot just think of replacement as simply replacing one contract with a new one. It’s more complicated than that. Under the NAIC Life Insurance and Annuities Replacement Model Regulation (MDL-613), a replacement is defined as a transaction in which a new policy/contract is to be purchased, and it is known to the proposing producer, that because of this transaction, an existing policy/contract has been or will be:

- Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer, or terminated;
- Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of non-forfeiture benefits or other policy values;
- Amended to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
- Reissued with any reduction in cash value;
- Used in financed purchase. A “financed purchase” means the purchase of a new policy or contract involving the actual or intended use of funds obtained by the withdrawal or surrender or the borrowing from values of an existing policy to pay all or part of any premium due on a new policy, issued by the same insurer. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company with four months before or 13 months after the effective date of
the new policy, it will be deemed that there is sufficient evidence of the policyholder’s intent to finance the purchase of the new policy with existing policy values.

Table 4.1 shows the states that have adopted the NAIC Life Insurance and Annuity Replacement Model Regulation.

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Source: NAIC as of 9/31/2014; http://www.naic.org/prod_serv_model_laws.htm

As a professional insurance producer, if and when, you are engaged in a case where replacement may seem to be called for, make sure you present a fair comparison between policies. Always request an in-force ledger from the existing insurer. Once you have the in-force ledger you can make a competent comparison that should include the contract benefits, the premiums, and the values. Explain the pros and cons to making the replacement. Inform your client of the new suicide and contestability periods and any surrender charges that will be part of the change (full disclosure). Finally, you and your clients must sign the replacement notices required by the state where you are soliciting the business and the company(ies) you are representing for that sale. If there are no state required forms, document your analysis and have clients sign the form acknowledging that they understand their decision to replace the contract.

IRC Section 1035 exchanges can meet the definition of replacement. If so, make sure you use the appropriate replacement forms and procedures. Failure to follow proper procedures when making 1035 exchanges can create an unnecessary tax liability for your client.

When evaluating whether or not a replacement is justified, be thorough in assessing the pros and cons. It is just as important to make certain that a replacement is suitable for the client as it is for any other sale. If a replacement benefits the client both on a long-term and short-term basis, and has no adverse effects, the replacement is probably justified. If there are adverse effects (reduced guaranteed values, higher loan rates, new suicide and contestability clauses,) it may not be justified.

Here are the insurance producer’s required duties when doing a replacement:
All applications require the insurance producer to obtain a statement indicating whether the applicant has existing policies/contracts. The producer and applicant must sign the statement. If there are no existing policies/contracts, the producer does not have to do anything further with respect to the replacement regulations.

If there are existing policies/contracts, the producer must present and read the Important Notice: Replacement of Life Insurance or Annuity Form (L-2968). The applicant and the producer must sign the Form attesting to the following, even if a replacement is not involved in the transaction:
- that the notice was read aloud or the applicant did not wish to have it read, and
- that a copy of the Form was left with the applicant no later than when the application is taken.

If a replacement is involved, the insurance producer must have the applicant list all policies/contracts proposed to be replaced on the Form, including the insurer, insured and contract number and indicate whether the policy/contract will be replaced or used to finance a new policy/contract.

The producer must leave the original and a copy of all sale materials with the applicant at the time the application is completed when a replacement is involved. For electronically presented materials, the producer must provide the applicant with a printed copy no later than policy/contract delivery. “Marketing communication” or “sales material” means a sales illustration and any other written, printed, or electronically presented information created or completed or provided by the insurer or agent, and used in the presentation to the policy or contract owner relating to the policy or contract. The producer must send the following information to the insurer along with the application:

- A completed and signed Replacement Form, which includes:
- A signed statement as to whether the applicant owns existing policies/contracts.
- A signed statement identifying any preprinted or electronically presented company-approved marketing communications used, and copies of any individualized marketing communications, including any illustrations related to the specific policy or contract purchased.

As was discussed above, “twisting” and “churning” are some of the terms often used to describe various types of inappropriate replacements. Twisting and churning are improper and most often illegal. They do not help clients, and they certainly will not benefit your career.

Sometimes replacements may create taxable events—especially if there are substantial policy loans. Potential tax implications of a replacement should always be a factor in deciding whether or not to replace a policy. The consequence of illegal replacement to an agent could include loss of license, monetary fines, and public disgrace. Failing to meet the requirements of replacement is always unethical.
Note: In some states, the law may be even more restrictive. It is critical that you know the law in your state. You can find out your state’s replacement regulations from your carriers or from the state’s insurance department.

To view the full document go to: http://www.naic.org/prod_serv_model_laws.htm

“Unauthorized Entities” Selling Insurance

There has been a major influx across the country of unscrupulous individuals and unauthorized entities selling phony insurance to unsuspecting consumers, especially health insurance.

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<td>What is an “unauthorized insurer?” State statutes answer the question this way: an “authorized” insurer is an insurer duly authorized by a certificate of authority issued by the states’ insurance department to transact insurance business in the state. An “unauthorized” insurer is one which has no certification of authority and is not so authorized.</td>
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Phony health insurers are pocketing millions of dollars in premiums while leaving their victims with huge unpaid medical bills. According to a recent report by The Commonwealth Fund, a New York-based independent foundation studying health policy, they wrote, “The United States is experiencing an unprecedented influx of unauthorized insurers selling phony health insurance. Unauthorized health insurance companies intentionally fail to comply with state and federal law regarding insurance regulation; they collect premiums for nonexistent health insurance; they do not pay claims and ultimately, they leave patients with millions of dollars in unpaid medical bills. Most victims have been small businesses and self-employed people. “Being victimized by a phony health insurance scam is worse than being uninsured,” Mila Koffman of the Health Policy Institute at Georgetown University, who lead the study, said in a statement. “Here, not only are you stuck with huge medical bills, you’ve also been defrauded thousands of dollars of premiums. Koffman and colleagues interviewed state insurance commissioners, insurance regulators, the Employee Benefits Security Administration—part of the U.S. Department of Labor—and other agencies for their report.

As a licensed insurance producer you have the responsibility to conduct “due diligence” on the products and services that you provide to your clients. As part of that due diligence you must take the time to educate yourself about the product, it services and the market. If you don’t, you will be faced with some of the risks and penalties associated with marketing and selling these plans. Penalties vary somewhat from state to state, but insurance producers selling bogus health care (or other) products offered by bogus companies risk license suspension or revocation, as well as holding the producer personally responsible and in some states be charged with a third class felony.
With the proliferation of these unauthorized insurance scams across the country many states have passed specific legislation to stop insurance producers from selling these programs.

**Annuity Suitability Model Regulation**

The National Association of Insurance Commissioners (NAIC) has taken specific actions dating back to 2000, that require both insurance producers and insurers selling annuities, take affirmative steps to ensure the suitability of the annuity for the consumer. Below, we will review the history of several Model Regulations passed by the NAIC to protect consumers when purchasing both fixed and/or variable annuities.

**Senior Protection in Annuity Transactions Model Regulation**

In 2000, the NAIC adopted a white paper calling for the development of suitability standards for non-registered products similar to those existed for some time under the Securities and Exchange Commission (SEC) for registered products (discussed below). The result of the white paper was a working group of the NAIC under the Life Insurance and Annuities Committee that drafted a model setting suitability standards for all life insurance and annuity products.

The NAIC Life Insurance and Annuity Committee decided to focus first on the area that had been identified as subject to the greatest abuse: the inappropriate sales of annuities to persons age 65 and over. The resulting *Senior Protection in Annuity Transactions Model Regulation* (“Suitability Model”) was adopted by the NAIC in 2003. This Model Regulation was another tool that regulators could use to protect consumers from inappropriate sales practices in addition to the NAIC’s Annuity Disclosure Model Regulation.

**2006 Suitability Model**

Then in 2006, still concerned about the abusive and unsuitable sales of both life insurance and annuity products not just to seniors, the NAIC membership overwhelmingly adopted revisions to the “Suitability Model” to have its requirements apply to all consumers regardless of age.

The amended “Suitability Model” imposes certain duties and responsibilities on insurers and insurance agents regarding the suitability of a sale or exchange of an annuity to a consumer. Specifically, in recommending to a consumer the purchase of an annuity or the exchange of an annuity, the insurance agent, or the insurer if no agent is involved, must have “reasonable grounds” for believing that the recommendation is suitable for the consumer. This is based on facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs. To ascertain the product’s suitability, prior to the execution of a purchase or exchange of the
recommended annuity, the insurance agent, or insurer if no agent is involved, must make all reasonable efforts to obtain information concerning:

- Consumer’s financial status;
- Consumer’s tax status;
- Consumer’s investment objectives, and
- Any other information used or considered to be reasonable in making the recommendation to the consumer.

However, since fixed annuities are not considered securities, they are regulated only by state departments of insurance and traditionally were not subject to the same suitability requirements as variable annuities. In March 2010, the NAIC took action to recommend model regulations to bring all annuities in line with existing securities regulations governing variable annuity transactions with *The 2010 NAIC Suitability in Annuity Transactions Model Regulation.*

### 2010 NAIC Suitability in Annuity Transactions Model Regulation

In 2010, the NAIC again amended the “Suitability Model” with the *2010 Suitability in Annuity Transactions Model Regulation.* To view the full document go to: [http://www.naic.org/store/free/MDL-275.pdf](http://www.naic.org/store/free/MDL-275.pdf)

The purpose of this Model Regulation was to set standards and procedures for suitable annuity recommendations for purchase and exchanges of an annuity (both fixed and variable), and requires insurers to establish a supervisory system.

Specifically, this Model Regulation was adopted to:

- Require insurance producers to have reasonable grounds for believing that the recommendation to by an annuity is suitable for the consumer;
- Establish a regulatory framework that holds insurers responsible for ensuring that annuity transactions are suitable (based on the criteria discussed below), whether or not the insurer contracts with a third party to supervise or monitor the recommendations made in the marketing and sale of annuities.
- Require that agents be trained on the provisions of annuities in general, and the specific products they are selling.
- Where feasible and rational, to make suitability standards consistent (a safe-harbor) with the suitability standards imposed by the Financial Industry Regulatory Authority (FINRA).

### Determining Suitability

As discussed above, the 2006 version of the NAIC Model Regulation required that, prior to recommending an annuity, an insurance producer or an insurer must make reasonable efforts to obtain information about the consumer's financial status, tax status, and
investment objectives, as well as other information that could be used in making a recommendation to the consumer.

However, the newly revised 2010 NAIC Model Regulation, Section 6, imposes a substantially higher benchmark for determining the "suitability" of all types of annuities, closely approximating FINRA standards applicable to variable annuity sales.

First, the 2010 Model Regulation requires that the insurance agent have "reasonable grounds" to believe that the annuity recommendation is suitable for the consumer. This suitability determination is to be made from "suitability information" disclosed by the consumer about his investments and other insurance products and his financial situation and needs. Such "suitability information" consists of 12 different factors, including the consumer's intended use of the annuity, financial time horizon, existing assets, liquidity needs, liquid net worth, and risk tolerance.

These suitability factors are clearly more expansive than the few listed in the 2006 version of the Model Regulation. They are:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial objectives;
- Financial experience;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Note: California added a 13th factor: Whether or not the consumer has a reverse mortgage.

Second, duties of insurers and of the insurance agent must also have a "reasonable basis" to believe that the annuity as a whole, its unique features, and the transaction itself are in the best interests of, and can be understood by, the consumer. Specifically, Under Section 6A, the insurance agent, or the insurer where no agent is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer’s suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer is reasonably informed of the annuity's features;
• The consumer will benefit from certain features of the annuity, such as tax-deferred growth, annuitization, or a death or living benefit;
• The particular transaction, the annuity as a whole, the underlying sub-accounts, and any riders and similar product enhancements are suitable for the particular consumer; and
• As applicable, the exchange or replacement is suitable, considering surrender charges, increased fees, benefits from product enhancements and improvements, and other exchanges or replacements within the preceding 36 months.

Both the 2006 and 2010 versions of the Model Regulation limit the agents' obligations to the consumer where the consumer refuses to provide complete or accurate suitability information or enters into an annuity transaction that expressly is not recommended. Section 6D of the 2010 Model Regulation states that neither an agent nor an insurer has any obligation to a consumer under the provisions of this regulation if:

• No recommendation is made;
• The consumer provided materially inaccurate information which led to an unsuitable recommendation;
• A consumer fails to provide relevant suitability information and the transaction is not recommended of an insurance agent.
• However, an insurer’s issuance of an annuity is to be reasonable under all circumstances actually known to the insurer, even if the situations listed above apply.

**Systems of Supervision and Training**

The 2010 Model Regulation, Section 6F, now provides additional guidance for establishing effective supervisory procedures.

Under the newly amended Model Regulation, insurance agents must make a record of any annuity recommendation and obtain a consumer signed statement if the consumer refuses to provide the required suitability information or decides to purchase an annuity not based on a recommendation.

In addition, prior to the issuance of an annuity contract, the insurer (or a third party with whom the insurer has contracted) must review annuity recommendations to ensure that there is a reasonable basis to believe the transaction is suitable. This may be accomplished by a screening system that would identify selected transactions for additional scrutiny.

The insurer also will be required to maintain reasonable procedures to detect recommendations that are not suitable, including confirming consumer suitability information, conducting customer surveys and interviews, sending confirmation letters and establishing internal monitoring programs.
Finally, the 2010 Model Regulation mandates that insurers train their insurance agents on the new suitability requirements and on the products themselves. Section 7A requires the insurance agent to have adequate product training, prior to soliciting an annuity product. In addition, Section 7B requires a one-time, minimum four (4) credit hour general annuity training course offered by an insurance-department approved educational provider and approved by an insurance department in accordance with applicable insurance education training laws or regulations. For this mandated course, the provider may not train in sales or marketing techniques or product specific information.

Section 7B (3) outlines the minimum required topics for this program of instruction, which can be offered in the classroom or via an insurance department approved self-study method. If an insurance agent is licensed with a life insurance line of authority prior to the effective date of the regulation, there is a six month grace period to comply with the training requirements; insurance agents who obtain the life authority on or after the effective date of the regulation must complete the training prior to the sale of an annuity product.

FINRA Compliance

It should be noted that under Section 6H of the Model Regulation's safe harbor provision, sales of annuities already in compliance with FINRA rules will comply with the new NAIC suitability regulation as well. Broker-Dealers may subject fixed annuity sales to FINRA suitability and supervision rules; and sales made in compliance with such rules would also qualify as complying with the NAIC suitability regulation. However, since, FINRA does not have authority to enforce its rules on the sale of fixed annuities, broker-dealers supervising fixed annuity sales may be subject to more intensive insurance examination than for the sale of security insurance products. Representatives of a broker-dealer, who are not required by the broker-dealer to comply with the FINRA requirements on the sale of fixed annuities, will have to comply with the insurance suitability regulation adopted by the state. In any case, insurers are responsible for any unsuitable annuity transactions no matter what suitability regulation or rule is applied by a broker-dealer.

The Wall Street Reform and Consumer Protection Act of 2010

As was discussed in Chapter 3, under Section 989J of the Wall Street Reform and Consumer Protection Act of 2010 (also known as the Harkin Amendment), it called for all states to adopt and enforce the NAIC 2010 Suitability in Annuities Transaction Model Regulation (Model Act 275). In addition, the Federal Insurance Office (FIO), which was created by the Act, also calls on the states to adopt the NAIC Model Act 275. The annuity suitability recommendation appears in the “marketplace oversight” section. It runs only 650 words, but annuity professionals will be perusing those words very carefully. The report states:

“The suitability of an annuity purchase should not be dependent upon the state in which the consumer resides,“
Reading between the lines, the underlying message is that this is no time for foot-dragging. All states need to adopt and implement the NAIC suitability model ASAP. If all states aren’t on board fairly soon, the feds might step in. According to the 71-page report:

“Given the importance of national suitability standards for consumers considering or purchasing annuities, states should adopt the Model Suitability Regulation. In the event that national uniformity is not achieved in the near term, federal action may become necessary.”

The last statement – that “federal action may be necessary” – will no doubt stir up a certain amount of industry murmuring. That is because, according to various published reports, many states have already adopted one version or another of the annuity suitability model developed by NAIC. “So why even bring this up?” some professionals will ask. Apparently, this has to do with the lack of uniformity among those regulations. As was discussed above, the NAIC has adopted three versions of its suitability model over the years. The 2003 version applies to sales involving senior buyers. The 2006 version updates the model to apply to consumers of all ages. And the 2010 model substantially strengthens the standards (by clarifying insurer compliance and producer education requirements, for example).

To bolster its case, the FIO researchers point out that the Dodd-Frank Act has two sets of provisions that incorporate this suitability model.

- One set of provisions essentially involves voluntary adoption. Here, the act provides “incentives” for state regulators to enact national suitability standards. These include grants for which states can apply to support efforts “to enhance the protection of seniors from misleading and fraudulent sales of financial products,” the researchers say. The catch is, in order to obtain the grants, the states must meet certain requirements, including a requirement to “adopt suitability standards that meet or exceed” those in the model regulation. They could choose not to adopt the standards, but then they won’t qualify for the grants.
- The second set of provisions moves closer to being an indirect requirement. Here, Dodd-Frank includes a direction to the Securities and Exchange Commission that involves both the suitability model and regulation of indexed annuities. This is the so-called Harkin Amendment, and it exempts indexed annuities from securities regulation. To get the exemption, an indexed annuity must meet certain standards. One of the standards is that the annuity must be issued in a state that has adopted the suitability model or be issued by an insurer whose nationwide practices meet or exceed the suitability model standards.

Currently, only thirty-five states have adopted the 2010 version (See Table 4.1), with more on the way. But the other states adopted the earlier versions or, in a few cases, they have entirely different suitability approaches in effect.
NAIC has put on a big push to spur the remaining states to adopt the 2010 version. But states handle NAIC model adoption in different ways and in accordance with their own laws. That means state adoption of this particular model, as with most models, has occurred over a period of years, not months.

Relative to that point, the FIO’s call for the states to achieve uniformity in the “near term” will be another source of concern. Annuity professionals and state regulators will ponder what “near term” means in this context. Within a few months? A year? Five years? When?

**Table 4.1**

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<td>WY</td>
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Source: NAIC; As of January 15, 2015, the following states have not adopted the 2010 Suitability Model: AL, AZ, AR, DE, GA, MA, ME, MO, MY, NV, NM, NC, PA, TN, VT, and VA.
**FINRA/SEC Suitability Regulations**

The Financial Industry Regulatory Authority (FINRA), previously known as the National Association of Security Dealers (NASD), is an independent self-regulatory organization charged with regulating the securities industry, including sellers of variable annuities. FINRA has issued several investor alerts on the topic of variable annuities and has issued a number of Rules pertaining to the sale and suitability of variable annuities (discussed below).

**FINRA Rule 2821**

Based on the findings of a joint report “Examinations Findings Regarding Broker-Dealer Sales of Variable Insurance Products” (Joint Report) which identified “weak practices” regarding the suitability of variable annuity sales practices for investors and the lack of adequate disclosure of the risks, fees and tax consequences, FINRA published Rule 2821.

FINRA Rule 2821 imposed stringent sales practice standards and supervisory requirements on the sale of variable annuities by its members. The Rule set forth disclosure and information-gathering responsibilities regarding the sale of deferred variable annuities, as well as supervisory requirements to increase disclosure and sales force training.

The key requirements of the rule include:

- **Suitability (Rule 2821(b))**: Requires that no recommendation shall be made unless reasonable efforts have been made to obtain, at a minimum, information concerning the customer’s:
  - Age,
  - Annual income,
  - Financial situation and needs,
  - Investment experience,
  - Investment objectives,
  - Intended use of the deferred variable annuity,
  - Investment time horizon,
  - Existing investment and life insurance holdings,
  - Liquidity needs,
  - Liquid net worth,
  - Risk tolerance, and
  - Tax status.

Under the new rules, the insurance agent/registered representative would be required to ascertain the following key pieces of information from the client:

- Has the client been informed of the unique features of the variable annuity?
• Does the client have a long-term objective?
  o Is the annuity and its underlying sub-accounts the right match for the particular client?

Once the suitability requirements are reviewed, the insurance agent/registered representative would need to sign off on their validity. At the end of the day, the insurance agent/registered representative should be able to answer yes to the above checklist of suitability guidelines.

• **Disclosure**: The member firm or its representative would be required to provide the client with a current prospectus and a separate, brief, “plain English” risk disclosure document highlighting the main features of the particular variable annuity transaction. Those features would include:
  o Liquidity issues, such as potential surrender charges and IRS penalties;
  o Sales charges;
  o Fees (including mortality and administrative fees, investment advisory fees and charges for riders or special features);
  o Federal tax treatment for variable annuities;
  o Any applicable state and local government premium taxes, and
  o Market risk.

The risk disclosure document would be required to inform the client whether a “free look” period applies to the variable annuity contract, during which the client could terminate the contract without paying any surrender charges and receive a refund of his or her purchase payments.

• **Principal Review (Rule 2821 (c))**: Requires that a registered principal must review and sign off on suitability and disclosure requirements, no later than seven (7) business day following the date when a firm’s office of supervisory jurisdiction (OSJ) receives a complete and correct application package. The registered principal will be required to retrace the suitability requirements that the writing agent addressed, including:
  o What is the client’s age and liquidity need?
  o Does the amount of money exceed a specific percentage of the client’s net worth or more than a set dollar amount?
  o Does the transaction involve an exchange or replacement?
  o Is the purchase of the VA for a tax-qualified retirement account?

If a transaction has an exchange or replacement clause, the registered principal would need to review and approve a separate exchange or replacement document. Justification for the FINRA’s new rules, according to the agency, is that the principal review requirements ultimately give the client the ability to review, complete and execute an application for a VA in a quick one-step process.
• *Training (Rule 2821 (e))*: Registered firms would be required to develop and document specific training policies or programs designed to ensure that registered representatives and registered principals comply with the rule’s requirements and that they understand the unique features of deferred variable annuities.


The SEC made several changes to Rule 2821.

• The rules application applies to the purchase or exchange (not sale or surrender) of a deferred variable annuity and the initial subaccount allocations.
• The rule does not apply to reallocations of sub-accounts made or to funds paid after the initial purchase or exchange of a deferred variable annuity. Note: There are other FINRA rules, however, that are applicable to such transactions. For instance, FINRA’s general suitability rule (FINRA Rule 2310) continues to apply to any recommendations to reallocate sub-accounts or to sell a deferred variable annuity. FINRA Rule 2821 applies to the use of deferred variable annuities to fund IRAs, but not to deferred variable annuities sold to certain tax-qualified, employer-sponsored retirement or benefit plans, unless a member firm makes a recommendation to an individual plan participant, in which case the rule would apply to that recommendation.
• “The new rule applies to sales to all investors and not just to seniors.

The SEC published the order approving the new rules in Release Number 34-56375, which relates to File Number SR-NASD-2004-183.

**FINRA Rule 2330**

January 2010, FINRA consolidated Rule 2821 on deferred variable annuities into FINRA Rule 2330. The consolidated rule establishes sales practice standards regarding recommended purchases and exchanges of deferred variable annuities. All of the rule’s provisions became applicable as of February 8, 2010. The rule has the following six main sections:

• General considerations, such as the rule’s applicability;
• Recommendation requirements, including suitability and disclosure obligations;
• Principal review and approval obligations;
• Requirements for establishing and maintaining supervisory procedures;
• Training obligations; and
• Supplementary material that addresses a variety of issues ranging from the handling of customer funds and checks to information gathering and sharing.
FINRA Rule 2111

As part of the process to develop a new consolidated rulebook (the Consolidated FINRA Rulebook), Regulatory Notice 09-25, calls for the elimination of FINRA Rule 2310 to be consolidated with the new FINRA Rule 2111 (“Suitability Rule”). The modified rule would codify various interpretations regarding the scope of the suitability rule, clarify the information to be gathered and used as part of a suitability analysis and create a clear exemption for recommended transactions involving institutional customers, subject to specified conditions.

- **Scope of FINRA Rule 2111:** FINRA Rule 2111 will explicitly apply suitability obligations to a recommended transaction or investment strategy involving a security or securities. In this regard, the Rule would codify longstanding SEC and FINRA decisions and other interpretations stating that FINRA Rule 2111 covers both recommended securities and strategies. FINRA also proposes to codify in one place the discussions of the three main suitability obligations (reasonable basis, customer specific and quantitative), which are currently located in various IMs following FINRA Rule 2310.

- **Information Gathering Regarding the Proposed Suitability Rule:** FINRA Rule 2111 contains a number of minor changes regarding the gathering and use of information as part of the suitability analysis. For instance, the information that must be analyzed in determining whether a recommendation is suitable would include not only information disclosed by the member firm’s or associated person’s reasonable efforts to obtain it, but also information about the customer that is “known by the member or associated person.” The Rule also requires members or associated persons to make reasonable efforts to obtain more information than is explicitly required by FINRA Rule 2310 (age, investment experience, investment time horizon, liquidity needs and risk tolerance).

FINRA Rule 2090: Know Your Customer

FINRA Rule 2090, will also transfer into the Consolidated FINRA Rulebook a modified version of NTSE Rule 405(1) requiring firms to use due diligence to know their customers and eliminate the NYSE version and its related supplementary material and rule interpretation. The Rule would eliminate paragraphs (2) and (3) of NYSE Rule 405 and their related supplementary materials and rule interpretations as duplicative of NASD provisions that FINRA has proposed (or will be proposing) to be transferred into the Consolidated FINRA Rulebook. For instance, NYSE Rule 405(2) (Supervision of Accounts) is duplicative of NASD Rule 3110 (c)(1)(C)(Customer Account Information) and 3011 (Anti Money Laundering Compliance Program) and, to a certain extent, the proposed modified version of NYSE Rule 405(1), discussed below.

FINRA Rule 2090, know-your-customer obligation, captures the main ethical standard of NYSE Rule 405(1). Firms would be required to use due diligence, in regard to the opening and maintenance of every account, to know the essential facts concerning every customer (including the customer’s financial profile and investment objectives or policy).
This information may be used to aid the firm in all aspects of the customer/broker relationship, including, among other things, determining whether to approve the account, where to assign the account, whether to extend margin (and the extent thereof) and whether the customer has the financial ability to pay for transactions. The obligation arises at the beginning of the customer/broker relationship and does not depend on whether a recommendation has been made.

**SEC Approves Consolidated FINRA Rules**

The SEC approved FINRA’s proposal (Regulatory Notice 09-25) to adopt rules governing know-your-customer (FINRA Rule 2090) and suitability (FINRA Rule 2111) obligations for the consolidated FINRA rulebook. The new rules are based in part on and replace provisions in the NASD and NYSE rules and are discussed below.

**Recent FINRA Disciplinary Action**

You may be asking yourself why we have so much regulation. This recent FINRA disciplinary action may give you the answer. In a recent case (7/2014) two registered representatives recommended and effected unsuitable VA transactions for their customers, causing their customers to pay unnecessary surrender fees on VAs that had only been held for two to three years, and incurring longer surrender periods on new VAs.

FINRA’s facts and figures give a good sense of the seriousness of the conduct. One of the brokers switched 140 customers who held 214 fixed or variable annuities to a VA issued by an unaffiliated third-party insurance company, costing the customers approximately $208,000 in unnecessary surrender penalties and earning the broker $380,235 in commissions. The other broker switched 66 customers who held 87 fixed or variable annuities to the same unaffiliated VA, costing the customers approximately $155,173 in unnecessary surrender penalties and earning the broker $196,684 in commissions. As a result of each replacement transaction, the customer incurred a new surrender period.

It gets worse. FINRA found that the brokers employed a “one size fits all” investment strategy, notwithstanding the diversity of their customer base. Although the customers were between the ages of 27 and 73, some were working and some were retiree, and they had varied net worth’s and income, the brokers classified all of their customers as having the same risk tolerance and primary investment objectives. In addition, the brokers switched substantially all of their customers into the same VA, the same rider, and the same asset allocation investment fund option.

Next, let’s discuss another major suitability controversy: placing an annuity inside a qualified retirement plan.
Benefits of Maintaining Suitability Standards

The benefits of maintaining suitability standards are the following:

- Avoid market conduct trouble.
- Increased customer satisfaction and trust.
- A Win-Win-Win Solution.

Avoid Market Conduct Trouble

As insurance professionals, when we prepared for our licensing exams, we read extensively about proper market conduct and the types of sales practices that could put our licenses in jeopardy. Every state Insurance Department has passed an Unfair Trade Practices Act that has laid out the types of unfair trade practices that can be costly and even put our careers in danger.

Increased Client Satisfaction

Paying attention to suitability will not just keep you on the right side of market compliance regulations it will also improve your business.

Let’s face it, without satisfied clients, insurance professional/financial advisors, cannot stay in business. That’s why it’s so important to take steps to ensure that clients are satisfied with the products that you present to them and purchase from you. Applying suitability standards to the recommendations you make will increase client satisfaction because clients will know you are helping them reach their financial goals and objectives. To borrow from an advertisement from a popular men and women’s clothing store, “An educated consumer is the best consumer.”

Remember that a satisfied client becomes a lifetime client and will more than likely purchase more than one product from you. In addition, fully satisfied clients will feel more comfortable in giving you referrals of other friends and family, and that will expand your business even further.

A Win-Win-Win Solution

Everyone wins when insurance producers and financial advisors make suitable recommendations. The insurance companies win, because lapse rates will fall, meaning that the business you worked so hard to put on the books will stay on the books. Renewal rates will improve. As an insurance producer/financial advisor you will win because building a long-term client relationship helps lock out the competition and gives you the inside track on meeting your clients’ other financial needs as they arise in the future. Most importantly, the clients win because they end up with products and services they need and receive full value for what they’ve paid for while meeting their financial goals.
Chapter 4
Review Questions

1. In what year was the original Unfair Marketing Practices Act created by the NAIC?
   ( ) A. 1940
   ( ) B. 1955
   ( ) C. 1960
   ( ) D. 1980

2. The revised Annuity Disclosure Model applies to which type of annuity? fixed annuities, index annuities and variable annuities.
   ( ) A. Fixed Annuity
   ( ) B. Variable Annuity
   ( ) C. Index Annuity
   ( ) D. All of the above

3. The 2010 NAIC Model Regulation requires "suitability information" that consists of at least how many different factors?
   ( ) A. Four
   ( ) B. Six
   ( ) C. Twelve
   ( ) D. Fifteen

4. Which of the following FINRA rules establishes sales practice standards regarding recommended purchases and exchanges of deferred variable annuities?
   ( ) A. FINRA 2111
   ( ) B. FINRA 2090
   ( ) C. FINRA 2330
   ( ) D. FINRA 2821

5. The 2010 NAIC Annuity Suitability Model requires a one-time, minimum of how many hours of general annuity training?
   ( ) A. 2 hours
   ( ) B. 3 hours
   ( ) C. 4 hours
   ( ) D. 8 hours
CHAPTER 5

NAVIAGTING ETHICAL DILEMMAS

Overview

As was discussed in Chapter 4, there are clearly defined unethical and deceptive sales practices that an insurance producer should completely avoid. However, for an insurance producer, not all ethical decisions are as clearly defined. There are also situations where it is less clear what is right or wrong. These situations create for us what we some call “ethical quandaries or dilemmas”, the so called “gray areas.” Ethical training might also be particularly vulnerable in these areas.

In this chapter, we will examine some of the ways to navigate these ethical dilemmas. The chapter will discuss steps to take to help frame how an ethics based decision may be made. It will also review several general ethical principles to live by and work by.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Determine how to navigate ethical dilemmas;
- Identify the steps to take in order to frame an ethics based decision;
- Recognize the importance of conducting an ethics self-examination; and
- Describe the general ethical principles to live by and work by.

Navigating Ethical Dilemmas

A quandary or dilemma is a situation where we are not sure what to do because there are good reasons for the action and good reasons against it. Such situations include those where there is a conflict of interest or obligation.

Steps to Ethical Decision Making

The ethical component of the decision making process takes the form of a set of “filters”. Their purpose is to separate the sought after elements from their containing environment.

The insurance producer at key steps in the process can stop and run his or her considerations through these filters and thereby separate the ethical conations from the remainder of the decision. This ensures that the ethical issues imbedded in the decision can be given consideration.
To make it easy to understand and apply these ethic filters we have adapted the mnemonic PLUS.

- **P = Policies**
  - Is it consistent with my organization’s policies?
- **L = Legal**
  - Is it acceptable under the applicable laws and regulations?
- **U = Universal**
  - Does it conform to the universal principles/values my organization has adopted?
- **S = Self**
  - Does it satisfy my personal definition of right, good and fair?

**Ethics Self Examination**

The adage, “an ounce of prevention is worth a pound of cure” applies well to market conduct and compliance. To meet one’s compliance responsibilities effectively and efficiently, compliance and market conduct activities need to be an integral part of an insurance producer’s operation and should not be a “tacked on” afterthought. A good way to integrate compliance and market conduct responsibilities into your normal business routine is to build compliance related activities into your plans so that they get accomplished along with everything else. Here are some specific tips in building compliance into your plans:

Determine your annual goals — incorporate compliance into your overall business goals. To identify what your important compliance goals may be, consider the following:

- Review compliance audit results for the last two or three years. What areas did auditors focus on for further development? Were there barriers to being prepared for the audit and how could they have been avoided?
- Review compliance issues that may have arisen in the previous year. For example, what company procedures created frustration and confusions for you or your administrative staff?
- Assess whether there are any compliance or market conduct issues that need to be considered with products that will be sold in the coming year.
- What are the continuing education requirements of the states in which you hold a license and what is the timing for meeting these requirements?
- Consider the markets you work in and whether there are compliance risks in those markets?
- Develop plans for achieving your goals. If you plan to facilitate a seminar, be sure to include the need to obtain approved seminar materials in a timely manner. Or, plan on hiring a new administrative associate, build into the plan the necessary compliance training that he or she will need.
- Create a compliance calendar — this can be a valuable tool for managing compliance activities, due dates, and responsibilities and serve as a reminder of key due dates. Some activities that should be listed on a compliance calendar include:
Removing old sales materials
- Updating manuals and procedures
- Preparing for company audits
- Attending local industry association meetings
- Attending required training programs
- Reviewing changes in laws and regulations using information communicated by companies
- Meeting continuing education requirements

By making compliance part of your overall plan, it is more likely that you will implement your compliance goals and reap the benefits of having them in place.

General Ethical Principles to Live By and Work By

A glance at today’s headlines or media reports quickly reveals that ethics, or a lack-there-of, is a persistent issue in America. While the high profile cases are obvious to any reader, a more in-depth review of the daily news will find abundant reports of unethical actions by students, teachers, business leaders, public officials and even elected officials at all levels of government and society.

Insurance producers do not act in an unethical manner by mistake. It takes an insurance producer making personal choices to participate in unethical acts to violate ethical practices. In fact, it seems obvious that an insurance producer is faced with ethical choices daily. These decisions are not always easy, and unfortunately, it is not uncommon for producers to be pressured by others to take actions that they may themselves consider to be unethical. Just as ethical values are the cornerstone of civilized society, they also form the foundation upon which individuals make their individual decisions.

People derive their ethical values from many different sources. Some people credit ethical lessons taught to them as a child: respect for authority, loyalty to family, honesty, self-control, and concern for others, among others. Others cite learning from historical examples, literature, religious principles, and personal observations and experiences.

While there are many differing sources and definitions of values, there are some basic ethical guidelines accepted by a vast majority of people. These include qualities such as trustworthiness, responsibility, respect, loyalty, compassion and fairness.

In the paragraphs that follow, we will review some of the general ethical principles to live by and work by. Let’s begin by reviewing honesty.

Honesty

There is no more fundamental ethical value than honesty. Honesty is a cornerstone of ethical behavior, for it means “telling the truth.” Someone who is honest takes care not to
deceive others, either by what they say or what they fail to say. For example, if an insurance producer told a prospect that a product had a 6% guaranteed return, we wouldn’t consider that insurance producer honest if the 6% return was guaranteed for only one year and the insurance producer didn’t make the one-year limit on the guarantee period clear to the prospect. The statement may have been accurate as far as it went, but the agent withheld a material fact which would likely result in a misunderstanding on the part of the prospect. Honesty requires telling the whole truth.

Earl Nightingale once considered the issue of honesty, and then he said:

“Every time you do something less than honest, you’re throwing a boomerang. How far it will travel no one knows. How great or small a circle it will travel only time will tell. But it will eventually, it must finally, it will inevitably, come around behind you and deliver a blow to you.”

According to Josephson Institute, “…honesty is a broader concept than many may realize. It involves both communications and conduct.”

**Honesty in communication** is expressing the truth as best we know it and not conveying it in a way likely to mislead or deceive. There are three dimensions:

- **Truthfulness.** Truthfulness is presenting the facts to the best of our knowledge. Intent is the crucial distinction between truthfulness and truth itself. Being wrong is not the same thing as lying, although honest mistakes can still damage trust insofar as they may show sloppy judgment.
- **Sincerity.** Sincerity is genuineness, being without trickery or duplicity. It precludes all acts, including half-truths, out-of-context statements, and even silence, that are intended to create beliefs or leave impressions that are untrue or misleading.
- **Candor.** In relationships involving legitimate expectations of trust, honesty may also require candor, forthrightness and frankness, imposing the obligation to volunteer information that another person needs to know.

Honesty in conduct is playing by the rules, without stealing, cheating, fraud, subterfuge and other trickery. Cheating is a particularly foul form of dishonesty because one not only seeks to deceive but to take advantage of those who are not cheating. It’s a two-for: a violation of both trust and fairness.

Honesty has connotations beyond mere communication to all types of action. Honesty means being fair as well as truthful. Honesty means making sure others receive what they are entitled to and not accepting things to which one is not entitled. Clients pay for an objective evaluation of their life insurance needs, for an objective recommendation about what will best meet their needs, and for ongoing service to assure that their needs are continually met, and they should get nothing less.

“No man for any considerable period can wear one face to
"himself, and another to the multitude without finally getting bewildered as to which may be true."

Nathaniel Hawthorne

Being honest is essential to creating the kind of trust in the insurance producer-client relationship that allows consumers to make an affirmative buying decision. Consumers aren’t going to buy life insurance from an insurance producer they think has been dishonest with them, nor will they refer that insurance producer to other people they know. Would you? At the same time, consumers are eager to work with insurance producers whom they know have made a competent evaluation of their life insurance needs and an objective recommendation regarding how they should meet those needs. In addition, insurance producers who handle themselves in an honest and professional manner have no trouble obtaining referrals to other high quality prospects.

**Integrity**

Integrity is similar to honesty, but integrity carries with it the connotation of being incorruptible no matter what the temptation to be dishonest. The word integrity comes from the same Latin root as “integer” or whole number. Like a whole number, an insurance producer of integrity is undivided and complete. This means that the ethical person acts according to his or her beliefs, not according to expediency. The ethical insurance producer is also consistent. There is no difference in the way he or she makes decisions from situation to situation; their principles don’t vary at work or at home, in public or alone. An insurance producer who has integrity does the right thing regardless of the consequences.

“One man cannot do right in one department of life whilst he is occupied in doing wrong in any other department. Life is one indivisible whole.”

Mahatma Gandhi

Some people only want to be honest as long as it doesn’t cost them too much. The price these people are willing to pay varies. For example, some might be willing to risk losing a small sale, but not a large one, for the sake of being honest. Some might be willing to risk losing any size sale, but not their job.

The higher degrees of honesty may be more commendable, but the highest degree of honesty and the most commendable, is being willing to risk anything and everything for the sake of being honest. That’s integrity.
Reliability (Promise-Keeping)

When we make promises or other commitments that create a legitimate basis for another person to rely upon us, we undertake special moral duties. We accept the responsibility of making all reasonable efforts to fulfill our commitments. When we make promises to our clients it is an important aspect of trustworthiness, it is important to:

- Avoid bad-faith excuses. Interpret your promises fairly and honestly. Don’t try to rationalize non-compliance.
- Avoid unwise commitments. Before making a promise consider carefully whether you are likely to keep it. Think about unknown or future events that could make it difficult, undesirable or impossible. Sometimes, all an insurance producer can promise is to do their best.

Responsibility

To be responsible is to be reliable and trustworthy. This is an essential element in the ethic of an insurance producer because, as we have said before, the insurance business is built on trust. The insurance producer possesses specialized knowledge of needs and products, which is not easily accessible to the average consumer. As a result, clients must rely on insurance producers for their professional expertise. Insurance producers have an ethical obligation to accept and fulfill their responsibilities to the best of their abilities.

When we are responsible we are in charge of our choices and thus, our lives. A responsible insurance producer knows that they are held accountable for what he or she does. It also means that the insurance producer recognizes that their actions matter and that they are morally on the hook for the consequences. Our capacity to reason and our freedom to choose make us morally autonomous and, therefore, answerable for whether we honor or degrade the ethical principles that give life meaning and purpose.

An ethical insurance producer shows responsibility by being accountable, pursuing excellence and exercising self-restraint.

Caring

If you existed alone in the universe, there would be no need for ethics and your heart could be cold, hard stone. Caring is the heart of ethics and ethical decision making. It is scarcely possible to be truly ethical and yet unconcerned with the welfare of others. That is because ethics is ultimately about good relations with people.

Caring is the motivation behind the work of the insurance producer. No amount of money or recognition is reward enough for the challenges that insurance producers must face day after day and year after year in their careers. The real payoff is knowing that they’ve helped people get their financial houses in order: that there will be cash and income to help keep a surviving family in their own world if a breadwinner should die prematurely, that a business can keep its doors open and continue to provide jobs and
services to the community when an owner is taken out of the picture, that individuals will have resources upon which they can count for the rest of their lives after they retire.

Caring is also the guide that enables insurance producers to act in their clients’ best interests. If an insurance producer cares about their clients, they will do for their clients what they would do for themselves if they were in the clients’ situation. Remember the golden rule – do unto others as you would have them do unto you.

**Selflessness**

Selflessness is the opposite of selfishness. Selfishness is a concern only with oneself and a disregard for others. After what we’ve said about caring, you should readily see that the life insurance business is no place for the selfish. Insurance producers have to put others first. But because the purpose of the insurance business is to be of service to others, insurance producers succeed the most by putting others first. By directly serving others’ best interests, they indirectly serve their own interests.

Selflessness also has a connotation of being generous, of giving more than the minimum required by any situation. Successful insurance producers find that the more they give to their clients, the more their clients give back to them.

**Courage**

It takes courage to be ethical. The right thing may always be the best thing in the long term, but in the short term there may be a price to pay. To be ethical, individuals may find that they have to stand up to a customer, or to an esteemed colleague, or to a superior, or even to their families who don’t want to risk the material loss that hewing to the ethical line might bring. It takes courage to stand up to those persons, whose expectations we are ordinarily eager to meet.

However, all the good intentions in the world don’t amount to anything unless one acts on one’s principles. Courage is the quality that converts ethical intention into ethical action.

On the positive side, courage is a universally admired trait. When individuals demonstrate that they have the courage to stand up for principle, they win the respect of their peers, their superiors, their customers, and their family. Individuals who at first feel alone when faced with an ethical situation requiring courage often end up finding a great deal of support for having done the right thing.

One situation that takes courage for an insurance producer is declining to work with an individual with whom the producer feels he or she could not establish a mutually beneficial professional relationship. For example, an insurance producer may be introduced to a prospect that doesn’t value ethical behavior. It’s hard to turn down the possibility of making a sale, but insurance producers must keep in mind that clients are likely to provide referrals to other people like themselves. Better to give up one sale than
to try to build a career out of ethically compromised actions. It’s easier and more profitable for insurance producers to work with ethical people who will appreciate the value of their services as well as their ethical orientation, and who will refer them to more people whose values they share.

**Excellence**

Excellence is the quality of being outstanding. To excel, to be the best one can be, certainly requires ethical behavior.

Gains obtained through unethical actions are lost eventually, and along with them reputation, self-esteem, trust, and perhaps the means of making one’s livelihood are also lost. On the other hand, the ethical individual builds success on solid ground. Gains obtained in an ethical manner compound themselves through the respect and confidence of customers and colleagues, and through the energizing effect of self-esteem.

In the insurance business, ethical behavior and excellence go hand in hand. As we discussed earlier, studies have shown that individuals who value ethical behavior are generally more successful in their careers than individuals who do not value ethical behavior.

Knowing that they have helped their clients is the motivation behind the work of all ethical life insurance agents.
Chapter 5
Review Questions

1. All of the following statements are correct about ethical dilemmas, EXCEPT?

   ( ) A. Not all ethical decisions are clearly defined
   ( ) B. It is less clear what is right and wrong
   ( ) C. All ethical decisions are clearly defined
   ( ) D. Ethical training may be vulnerable in these areas

2. Which of the following is NOT a step in the ethical decision making process?

   ( ) A. Is it consistent with my organizations policies?
   ( ) B. Is it acceptable under the applicable laws and regulations?
   ( ) C. Does it conform to the universal principles/values my organization has adopted?
   ( ) D. Will my earnings increase?

3. All of the following are general ethical principles to live by and work by, EXCEPT?

   ( ) A. Honesty
   ( ) B. Greed
   ( ) C. Integrity
   ( ) D. Selflessness

4. What is the most fundamental ethical value for an insurance producer?

   ( ) A. Honesty
   ( ) B. Caring
   ( ) C. Courage
   ( ) D. Selflessness

5. What is the heart of ethics and ethical decision making?

   ( ) A. Caring
   ( ) B. Courage
   ( ) C. Selflessness
   ( ) D. Honesty
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CHAPTER 6

CODES OF ETHICS

Overview

A Code of Ethics is a written set of guidelines which often conveys organizational values, a commitment to standards, and communicates a set of ideas. In practice, Code of Ethics is used interchangeably with codes of conduct. As was discussed throughout this book, ethical behavior is crucial to preserving not only the trust on which insurance transactions are based, but also the public’s trust in our industry as a whole.

In this Chapter, we will define a Code of Ethics and review its relation to Codes of Conduct. It will also examine the reasons for maintaining a Code of Ethics, how to develop a Code of Ethics and how to live and work by it. At the end of the chapter, you will review actual Codes of Ethics from several professional insurance and financial organizations.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Define Codes of Ethics;
- Understand the relationship of Codes of Ethics with Codes of Conduct;
- Distinguish the importance of Codes of Ethics and Codes of Conduct;
- Know how Codes of Ethics are developed;
- Realize the importance to live by and work by a Code of Ethics; and
- Recognize several insurance and financial professional organizations Code of Ethics.

Code of Ethics Defined

A code of ethics is a set of principles of conduct within an organization that guide decision making and behavior. The purpose of the code is to provide members and other interested persons with guidelines for making ethical choices in the conduct of their work. Professional integrity is the cornerstone of many employees' credibility. Member of an organization adopt a code of ethics to share a dedication to ethical behavior and adopt this code to declare the organization's principles and standards of practice.
In Section 406 (c), the Sarbanes-Oxley Act defines “code of ethics” as such standards as are reasonably necessary to promote:

- Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
- Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the insurer; and
- Compliance with applicable governmental rules and regulations.

**Code of Conduct**

*Code of conduct* specifies actions and code of ethics are general guides to decisions about those actions. The following steps are employed to develop a code of conduct:

- Identify key behaviors needed to adhere to the ethical values proclaimed in the code of ethics, including ethical values derived from review of key laws and regulations, ethical behaviors needed in your product or service area, behaviors to address current issues in the workplace, and behaviors needed to reach strategic goals.
- Include wording that indicates that all members of the organization are expected to conform to the behaviors specified in the code of conduct.
- Obtain review from key members of the organization.
- Announce and distribute the code of conduct.
- Include examples of topics typically addressed by code of conduct, such as:
  - Illegal drugs
  - Reliability
  - Confidentiality
  - Not accepting personal gifts from clients as a result of company role
  - Avoiding sexual or racial discrimination
  - Avoiding conflicts of interest
  - Complying with laws and regulations
  - Not using the organization's property for personal use
  - Reporting illegal or questionable activities

**Reasons for a Code of Ethics**

There are three major reasons why professions develop a code of ethics (or code of conduct). They are:

- To regulate members’ behavior — to inform them of expected behavior; to remind them that ethical behavior overrides many other considerations; to remind them of personal responsibility.
- To hold members accountable — to provide bases for judging in cases of breach; to help address situations where conflicting views of what is right are possible.
To present profession to society — to state its ethical bases, reassure stakeholders, and give them a basis for evaluating professionals.

A code of ethics generally describes the highest values to which a company or industry aspires to operate. It contains the ‘thou shalt’s’. A code of ethics specifies the ethical rules of operation. It is the ‘thou shalt not’s. More than 76% of companies surveyed by The Conference Board, a leading business membership organization, have a code of ethics.

Some business ethicists disagree that codes have any value. Usually they explain that too much focus is put on the codes themselves, and that codes themselves are not influential in managing ethics in the workplace. Many ethicists note that it is the developing and continuing dialogue around the codes values that is most important. Occasionally, members of an organization react to codes with suspicion, believing that values are like “motherhood and apple pie” and codes are for window dressing. But, when managing a complex issue, especially in a crisis, having a code is critical. Some organizations update and continue to develop their code of ethics in challenge meetings. They ask each individual “do we still believe this?” and, if fine tuning is needed, the codes are amended. In most cases, only minor points are fine-tuned — the values underlying the code are not amended.

**Developing a Code of Ethics**

A code of ethics is a formal document rather than merely an "environment," an "understanding," a consensus, "unwritten rule," or just an aspect of "corporate culture." It is at minimum a published document. In many organizations employees are also required to sign a statement to the effect that they have read and understood it. Variations on this theme exist. In very large corporations or corporations reacting to recent scandals, sometimes only corporate officers or only financial officers are required to sign. In other cases multiple codes of ethics may exist tailor-made to such functions as purchasing, sales, accounting, etc.

Codes of ethics are free-standing expressions of corporate will even when they are published as chapters or sections in a document which may contain a mission statement, a listing of corporate values, and general policies relating to operations.

The format of a code of ethics can vary widely. Unlike more straightforward employee guidelines and codes, this document typically is divided into four distinct elements:

- An introduction or preamble,
- A statement of purposes and values,
- Specific rules of conduct which may be subdivided in various ways, and
- Implementation of the code, which will define administrative processes, reporting, and sanctions.
Below are some guidelines employed by most professional and business organizations when developing a code of ethics:

- Relevant laws and regulations are reviewed—this ensures the organization is not breaking any relevant laws or regulations.
- Values which produce the top three or four traits of a highly ethical and successful service or product in the industry are reviewed—Objectivity, confidentiality, accuracy, etc. Values are identified that produce behaviors that exhibit these traits.
- Values needed to address current issues in the industry are identified—descriptions of major issues in the workplace or industry are collected. Then descriptions of the behaviors that produce those issues are defined and reviewed for those which are ethical in nature, e.g., issues in regard to respect, fairness and honesty. The behaviors that are needed to resolve these issues are defined, and the values that generate these preferred behaviors are listed. There may be values included that some people would not deem as moral or ethical values, (team-building, promptness, etc.), but these special values may add utility to a code of ethics.
- Evaluate the industry’s SWOT—Strengths, Weaknesses, Opportunities and Threats. Determine what behaviors are needed to build on strengths, shore up weaknesses, take advantage of opportunities and guard against threats.
- Top ethical values that might be prized by the consumer are considered—for example, the expectations of clients and customers, underwriters, agencies, the community, etc.
- The top five to ten ethical values which are high priorities in the industry are collected examples of ethical values might include some of the following:
  - Trustworthiness: honesty, integrity, promise keeping, and loyalty.
  - Respect: autonomy, privacy, dignity, courtesy, tolerance, acceptance.
  - Responsibility: accountability, pursuit of excellence.
  - Caring: compassion, consideration, giving, sharing, kindness, loving.
  - Justice and fairness: procedural fairness, impartiality, consistency, equity, equality, due process.
  - Civic virtue and citizenship: law abiding, community service, protection of business environment.
- Behaviors are associated with values—critics of codes of ethics assert the codes may seem vacuous because many only list ethical values but do not clarify these values by associating examples of behaviors.
- Input from members of the industry is solicited—ideas and input from as many leaders of the industry as possible are included.
- The code is reviewed regularly - the most important aspect of the code of ethics is in its development; the code should be reviewed every year for relevance. Continued dialogue and reflection around ethical values produces ethical sensitivity and consensus.
- Goals are refined – it is not possible to include in a code of ethics for every possible ethical dilemma that might arise. The goal is to focus on top ethical values needed in the organization and avoid potential ethical dilemmas that seem most likely to occur.
Live By a Code of Ethics

One good way to establish, maintain, or enhance our ethical standards is to review and live by a code of ethics. Practicing high ethics is the job of everyone in our industry.

The code of ethics developed by professional associations applies general ethical concepts to the specific types of activities in which those professionals engage. In the insurance and financial services business, codes of ethics have been developed by a number of organizations. To provide a standard for ethical conduct, we will devote the final chapter to a sampling of some of those codes of ethics.

Next, let’s examine some specific Codes of Ethics of insurance and financial professional organizations.

Professional Codes of Ethics

Perhaps the best-known code of ethics in history is the Hippocratic Oath taken by all doctors. Contrary to common belief, that oath does not include the phrase "First, do no harm." The actual language, in the third paragraph of the classical version, states: "I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice." According to Bartlett's Familiar Quotations, the more famous phrase comes from Hippocrates' Epidemics: "As to diseases make a habit of two things—to help, or at least, to do no harm."

In the next few pages we will examine the Codes of Ethics of the following professional organizations:

- National Association of Insurance and Financial Advisors  
- Independent Insurance Agents & Brokers of America, Inc.  
- Certified Financial Planners Board of Standards, Inc.  
- The Million Dollar Round Table

Read through all of these sample codes carefully. In them you will find expressed many of the ethical principles we have discussed in this course. As powerful encapsulated statements of the more detailed discussions we have covered in previous chapters, these codes of ethics will serve to consolidate your knowledge of ethical concepts and enhance the positive effect of your training efforts.

Let’s begin with the Code of Ethics from the National Association of Insurance and Financial Advisors (NAIFA).
National Association of Insurance and Financial Advisors (NAIFA)

The National Association of Insurance and Financial Advisors (NAIFA) is a national nonprofit organization representing the interests of more than 70,000 insurance and financial advisors nationwide, through its federation of over 900 state and local associations. Founded in 1890 as the National Association of Life Underwriters, NAIFA is the nation’s largest financial services membership association. Its mission is to advocate for a positive legislative and regulatory environment, enhance business and professional skills, and promote the ethical conduct of our members.

NAIFA corporate offices are located in Falls Church, Virginia. If you seek additional information, contact member services Toll Free at 877-TO-NAIFA or email at membersupport@naifa.org.

Code of Ethics

Preamble: Helping my clients protect their assets and establish financial security, independence and economic freedom for themselves and those they care about is a noble endeavor and deserves my promise to support high standards of integrity, trust professionalism throughout my career as an insurance and financial professional. With these principles as a foundation, I freely accept the following obligations:

- To help maintain my clients’ confidences and protect their right to privacy.
- To work diligently to satisfy the needs of my clients.
- To present, accurately and honestly, all facts essential to my clients’ financial decisions.
- To render timely and proper service to my clients and ultimately their beneficiaries.
- To continually enhance professionalism by developing my skills and increasing my knowledge through education.
- To obey the letter and spirit of all laws and regulations which govern my profession.
- To conduct all business dealings in a manner which would reflect favorably on NAIFA and my profession.
- To cooperate with others whose services best promote the interest of my clients.
- To protect the financial interests of my clients, their financial products and my profession, through political advocacy.

Adopted July 2012, Board of Trustees
National Association of Health Underwriters (NAHU)

The National Association of Health Underwriters (NAHU) founded back in 1930, represents more than 100,000 licensed health insurance agents, brokers, general agents, consultants and benefit professionals through more than 200 chapters across America. More information about NAHU can be found on their website www.nahu.org.

NAHU members embrace a strict code of ethics and constantly seek to improve their knowledge of health, insurance regulations and products through continuous education.

Code of Ethics

- To hold the selling, service and administration of health insurance and related products and services as a professional and public trust and do all in my power to maintain its prestige.
- To keep paramount the needs of those whom I serve.
- To respect my clients’ trust in me, and to never do anything which would betray their trust or confidence.
- To give all service possible when service is needed.
- To present policies factually and accurately, providing all information necessary for the issuance of sound insurance coverage to the public I serve.
- To use no advertising which I know may be false or misleading.
- To consider the sale, service and administration of health insurance and related products and services as a career, to know and abide by the laws of any jurisdiction Federal and State in which I practice and seek constantly to increase my knowledge and improve my ability to meet the needs of my clients.
- To be fair and just to my competitors, and to engage in no practices which may reflect unfavorably on myself, or my industry.
- To treat prospects, clients and companies fairly by submitting applications which reveal all available information pertinent to underwriting a policy.
- To extend honest and professional conduct to my clients, associates, fellow agents and brokers, and the company or companies whose products I represent.

Independent Insurance Agents & Brokers of America, Inc.

The Independent Insurance Agents & Brokers of America (Big "I") is a national alliance of more than a quarter million business owners and their employees who offer all types of insurance and financial services products.

Big "I" was founded in 1896 as the National Local Association of Fire Insurance Agents. With the expansion of property-casualty business and coverages, the organization’s name was changed to the National Association of Insurance Agents in 1913. To emphasize its members’ ability to work with a variety of insurance companies, the organization became the Independent Insurance Agents of America in 1975. The Association’s name was
changed in 2002 to the Independent Insurance Agents & Brokers of America to reflect the diversity of its membership, which includes both independent insurance agents and insurance brokers.

Big "I" is a voluntary federation of state associations and local boards, with affiliates in every state and the District of Columbia.

**Code of Ethics**

I believe in the value and importance of the insurance business and its future, and that the Independent Insurance Agent plays a critical role in serving consumers throughout the insurance process.

I support the Independent Agency System, which has developed insurance to be a fundamental component in the economic fabric of our nation, and I pledge to support right principles and oppose bad practices in the insurance business.

I respect the importance of the relationship between Independent Insurance Agents and the public, insurance companies, and other Independent Insurance Agents, and believe that the rights of the client are paramount.

**To the Public**

I believe that serving the public as an Independent Insurance Agent is an honorable occupation, affording me a special opportunity to serve society and offer valuable insurance products and services to the public.

I believe that as an Independent Insurance Agent, I am serving the interests of my clients by responding to their expressed insurance needs.

I will strive to further the public's understanding of insurance, endeavor to promote safety and loss control in my community, and strive to participate in civic and philanthropic activities that contribute to my community.

**To the Insurance Companies I Represent**

I will respect the authority vested in me by the insurance companies I represent, and work to maintain open lines of communication with them.

**To Other Independent Insurance Agents**

I will strive to maintain positive relations with other insurance agencies in my community, competing with them on an honorable and fair basis.

I will follow all insurance laws relative to the conduct of my business.
I will work with other Independent Insurance Agents for the betterment of the insurance business, and endeavor to elevate the standards of my occupation by following this Code of Ethics and encouraging other Independent Insurance Agents to do likewise.


The Certified Financial Planners Board of Standards, Inc. (CFP®)

When it comes to ethics and professional responsibility, CFP® professionals are held to the highest of standards. They are obliged to uphold the principles of integrity, objectivity, competence, fairness, confidentiality, professionalism and diligence as outlined in CFP Board’s Code of Ethics (see below). As of December 31, 2014, there were 71,296 CFP Certificants. For additional information about the CFP Board go to: http://www.cfp.net/about-cfp-board/cfp-certification-the-standard-of-excellence

CFP Code of Ethics

Code of Ethics & Professional Responsibility CFP Board adopted the Code of Ethics to establish the highest principles and standards. These Principles are general statements expressing the ethical and professional ideals certificants and registrants are expected to display in their professional activities. As such, the Principles are aspirational in character and provide a source of guidance for certificants and registrants. The Principles form the basis of CFP Board's Rules of Conduct, Practice Standards. The Code of Ethics consists of the seven Principles. These Principles of the Code establish the individual CFP Board designee’s responsibilities to the public, to clients, to colleagues, employers and to the profession. They apply to all CFP Board designees and provide guidance to them in the performance of their professional services.

Principle 1: Integrity.

The first principle is Integrity, which refers to candor, honesty, and trust. The code states:

“A CFP Board designee shall offer and provide professional services with integrity. CFP Board designee is placed by clients in positions of trust and confidence. The ultimate source of public trust is the CFP Board designee’s personal integrity. In deciding what is right and just, a CFP Board designee should rely on his or her integrity as the appropriate touchstone. Integrity demands honesty and candor that must not be subordinated to personal gain and advantage. Within the characteristics of integrity, allowance can be made for legitimate difference of opinion; but integrity cannot co-exist with deceit or subordination of one’s principles. Integrity requires the CFP Board designee to observe not only the letter but also the spirit of the Code.”

In terms of actions that violate the principle of integrity, the allegations of misrepresentation are the most common client complaint heard by the CFP Board’s Board of Professional Review (BOPR). For example, promised a better return than
actually received, did not make sure they understood the risks of a recommendation, failed to explain the tax consequences of a recommendation or did not disclose the fees associated with a recommendation.

To avoid these allegations CFP Board designees should take the steps necessary to ensure that clients fully understand all aspects of a recommendation. It certainly is not enough to simply give a client a prospectus and have them sign a disclosure statement.

**Principle 2: Objectivity**

The second principle is **Objectivity**, which refers to intellectual honesty, impartiality and states:

“A CFP Board designee shall be objective in providing professional services to clients. Objectivity is an essential quality for any professional. Regardless of the particular service rendered or the capacity in which a CFP Board designee functions, a CFP Board designee should protect the integrity of his or her work, maintain objectivity, and avoid subordination of his or her judgment that would be in violation of this Code.”

Objectivity also means exercising reasonable and prudent professional judgment and acting the interests of clients. The most common client complaint the BOPR has related to the principle of objectivity is that the planner did not provide the care and attention the client expected. Pulling together adequate procedures to communicate with the clients on a regular basis can go a long way to avoiding this complaint.

**Principle 3: Competence**

The third principle is Competence. This principle describes the need to attain and maintain professional skills and to recognize professional limitations and states:

“A CFP Board designee shall provide services to clients competently and maintain the necessary knowledge and skill to continue to do so in those areas in which the CFP Board designee is engaged. One is competent only when one has attained and maintained an adequate level of knowledge and skill, and applies that knowledge effectively in providing services to clients. Competence also includes the wisdom to recognize the limitations of that knowledge and when consultation or client referral is appropriate.

“A CFP Board designee, by virtue of having earned the CFP® designation, is deemed to be qualified to practice financial planning. However, in addition to assimilating the common body of knowledge required and acquiring the necessary experience for designation, a CFP Board designee shall make a continuing commitment to learning and professional improvement”
The most common client complaint the BOPR has related to the principle of competence is when the planners try to do too much. As stated before, it’s important for CFP Board designee to recognize their limitations and have procedures in place for referring clients to other competent professionals when appropriate.

** Principle 4: Fairness **

The fourth principle is Fairness. This principle directs CFP Board designee to perform services that are fair and reasonable to clients, principles, partners, and employers. It also discusses disclosing any possible conflict(s) of interest and states:

“A CFP Board designee shall perform professional services in a manner that is fair and reasonable to clients, principals, partners and employers, and shall disclose conflict(s) of interest in providing such services. Fairness requires impartiality, intellectual honesty, and disclosure of conflicts(s) of interest. It involves a subordination of one’s own feelings, prejudices, and desires so as to achieve a proper balance of conflicting interests. Fairness is treating others in the same fashion that you would want to be treated and is an essential trait of any profession.”

The Golden Rule: “Do unto others as you would have them do unto you.” This rule implies that an ethical person is concerned not only with themselves but also with the well-being of others.

** Principle 5: Confidentiality **

The fifth principle is Confidentiality which covers the proper disclosure of information concerning clients, co-owners, and employers and states that:

“A CFP Board designee shall not disclose any confidential client information without the specific consent of the client unless in response to proper legal process, to defend against charges of wrongdoing by the CFP Board designee or in connection with a civil dispute between the CFP Board designee and client.”

A CFP Board designee must safeguard the confidentiality of client information to develop a relationship based on personal trust.

** Principle 6: Professionalism **

The sixth principle is Professionalism. This principle explains how our professional conduct reflects upon our profession and states:

“A CFP Board designee’s conduct in all matters shall reflect credit upon the profession. A CFP Board designee shall behave in a manner that maintains the good reputation of the profession and its ability to serve the public interest. A
CFP Board designee shall avoid activities that adversely affect the quality of his or her professional advice.

“This principle focuses on a CFP Board designee’s conduct as it reflects on the CFP certification marks and the financial planning profession,” explains Margaret Brock, Director of Profession Review at CFP Board.

Under the principle of professional, CFP Board designees must abide by all applicable laws, rules and regulations of governmental agencies or authorities. Certain actions, such as criminal conviction or professional suspension, must be reported to CFP Board within 10 days (see Art. 12.2 CFP Board’s Disciplinary Rules and Procedures). Often actions, for example, a client arbitrage or NASD investigation must be disclosed during the certification application or renewal process, although the designee has the option of reporting earlier.

Also under the principles of professionalism, CFP Board designees must report any violations of the Code of Ethics by another designee to both the CFP Board and other appropriate regulatory bodies.

**Principle 7: Diligence**

The seventh and final principle is Diligence, which informs us that services to clients must be performed in a prompt and thorough manner and also states:

“A CFP Board designee shall act diligently in providing professional services. Diligence is the provisions of services in a prompt and thorough manner. Diligence also includes proper planning for and supervision of the rendering of professional services.”

Placing a client in a variable annuity when the client has no need of a death benefit is an example of a case the CFP Board might hear that centers on the issue of suitability.

The requirement of diligence extends to supervisory activities as well. For example, if a CFP Board designee supervises an individual whose actions are in conflict with the Code of Ethics, the CFP Board designee could be held in violation of the Code of Ethics whether or not the subordinate is a CFP Board designee.

**Million Dollar Round Table (MDRT)**

The Million Dollar Round Table is an organization whose members qualify for inclusion by meeting certain production and persistency objectives over the course of the year. Considered to be among the most prestigious of life insurance sales organizations, the MDRT is headquartered in Park Ridge, Illinois.
Code of Ethics

Members of the Million Dollar Round Table should be ever mindful that complete compliance with and observance of the Code of Ethics of the Million Dollar Round Table shall serve to promote the highest quality standards of membership. These standards will be beneficial to the public and the life insurance industry; and its related financial products. Therefore, members and provisional applicants shall:

- Always place the best interests of their clients above their own direct or indirect interests.
- Maintain the highest standards of professional competence and give the best possible advice to clients by seeking to maintain and improve professional knowledge, skills, and competence.
- Hold in the strictest confidence, and consider as privileged, all business and personal information pertaining to their clients’ affairs.
- Make full and adequate disclosures of all facts necessary to enable their clients to make informed decisions.
- Maintain personal conduct which will reflect favorably on the life insurance industry and the Million Dollar Round Table.
- Determine that any replacement of a life insurance or financial product must be beneficial for the client.
- Abide by and conform to all provisions of the laws and regulations in the jurisdictions in which they do business.
Chapter 6
Review Questions

1. Which of the following statements about Code of Ethics is FALSE?
   ( ) A. Code of Ethics generally describes penalties for noncompliance
   ( ) B. Code of Ethics often conveys organizational values
   ( ) C. Code of Ethics is used interchangeably with Code of Conduct
   ( ) D. Code of Ethics specify the ethical rules of operation

2. Which of the following are reasons why professionals develop a Code of Ethics?
   ( ) A. To regulate members behavior
   ( ) B. To hold members accountable
   ( ) C. To present profession to society
   ( ) D. All of the above

3. Code of Ethics is interchangeable with:
   ( ) A. Code of Honor
   ( ) B. Code of Conduct
   ( ) C. Code of Compliance
   ( ) D. Code of Respect

4. Code of Conduct specifies:
   ( ) A. Actions
   ( ) B. Words
   ( ) C. Thought
   ( ) D. Respect

5. Which professional organization’s Code of Ethics consists of seven Principles?
   ( ) A. American Society of Certified Property and Casualty Underwriters
   ( ) B. Certified Financial Planners Board of Standards, Inc.
   ( ) C. Society of Financial Service Professionals
   ( ) D. National Association of Health Underwriters
# CHAPTER REVIEW

## ANSWERS

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