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Continuing Education

Understanding Umbrella Insurance

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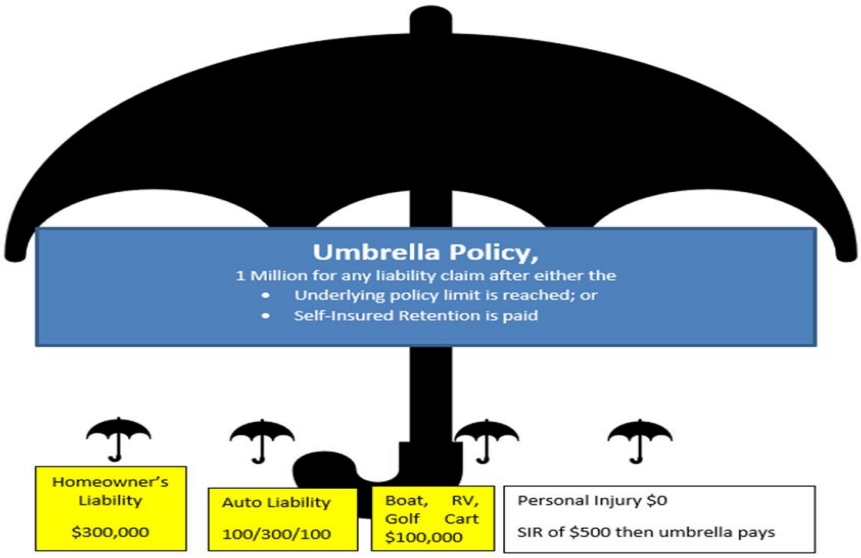

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CHAPTER 1: WHY LIABILITY INSURANCE

LIABILITY & THE LAW

Liability insurance provides protection for certain violations of civil law. Civil law is involved when an individual takes action against another individual who has suffered a loss as a result of another person's actions.

There are two forms of civil violations. There is the violation of contract law or the violation of a tort. Contract law is violated when one individual enters into a contractual agreement with another and then violates the agreement thus causing harm to the second party. Tort law is violated when an individual's legal or natural rights are violated, a destruction of someone's property, their person, or their well-being.

Individuals owe other individuals the responsibility not to deliberately act in a manner that might cause injuries to that other individual or their property.

Liability insurance usually applies to an individual's unintentional tort or wrongdoing.

Torts are categorized in three categories- intentional, strict liability and negligence. Intentional is a guided action performed with a deliberate intent to harm another individual. A strict liability is a liability imposed as a matter of law, even though the individual may not have caused the damage intentionally.

Negligence is defined as the failure to use care.

- ✓ To establish negligence four criteria must be met:
- ✓ A legal duty must be owed by the wrongdoer to the claimant;
- ✓ A breach of duty must be established;
- ✓ Actual damage must be suffered;

Direct causal relationship must be established.

There are three forms of negligence:

- ✓ Gross negligence;
- ✓ Contributory negligence;
- ✓ Comparative negligence.

Gross negligence occurs when there is a total disregard for the safety of others.

Contributory negligence occurs when one party's care for themselves falls below a required standard and together with the other parties negligence contributed to their harm.

Comparative negligence occurs when a weighing of the seriousness of negligence on the part of each party is measured in a contributory negligence case.

An important factor in a negligence case would be; did the individual willfully and knowingly exposes himself or herself to the possibility of injury or harm. This factor is known as the Assumption of Risk factor. An individual's willingness to be involved in the risk often weighs heavily on compensatory damage payouts.

Liability insurance provides protection in the event of a lawsuit by an aggrieved individual.

There are three types of liability coverage:

- Personal;
- Business;
- Professional.

Personal liability involves a home, a car, personal activities, and indirect or vicarious responsibilities for acts of children, pets etc.

Business liability involves the operation of a business, a store, a manufacturing plant, or a service type establishment.

Business liability claims can arise from:

- The ownership, maintenance or use of stores, warehouses, plants, offices, etc.
- The use of automobiles, trucks, and other vehicles.
- The actions of employees, agents, contractors, sub contractors or other representatives.
- Extension of liabilities through contractual agreements with other parties.
- Defects in goods or services.

Professional liability involves possible errors or omissions in the pursuit of a profession such as accountant, doctor, lawyer, real estate agent, etc.

THE PROTECTIONS OFFERED BY LIABILITY INSURANCE

Liability insurance protects the insured from the financial loss, should a claim arise, by transferring the risk to an insurance company in exchange for a premium. The most common coverage is against bodily injury and property damage.

Basic coverage is normally not universal and has limitations. To provide coverage over and above the "basics" provided by most policies umbrella liability insurance was created.

An "umbrella" provides protection over a broad range of factors or elements. Umbrella liability forms an "umbrella" over a broad range of other liability insurance to provide supplemental protection for losses, which would not otherwise be covered.

Umbrella insurance can provide:

- Coverage for catastrophic situations;
- Higher limits of liability for losses not typically covered by the primary policy;
- Coverage for losses not typically covered.

COMPONENTS OF AN UMBRELLA POLICY

The Declaration page contains information about the risk that is used for coverage and rating purposes.

The Insuring Agreement portion of the policy defines what the insurance company is willing to do for the insured.

The limit of insurance portion outlines the limit at which the company is no longer obligated to pay.

Other components of an umbrella policy that will be discussed in later chapters include:

Retained limits;

Self-insured Retention;

Defense and Settlement limits;

Territory of coverage.

Typically, it might be noted that a policy covering defense costs will cover bail bonds up to a specified limit, pay premiums on appeal bonds, court costs, and interest accruing after a judgment is entered.

COMMON UMBRELLA POLICY EXCLUSIONS

Because umbrella policies are not standardized, exclusions will differ from company to company.

The most common exclusions include:

- Obligations under workers compensation;
- Obligations under unemployment compensation;
- Obligations under disability benefits;
- Damage to property owned, rented, leased, or occupied by the insured;
- Damage to property in the insured's care, custody, or control;
- Damage to premises that have been sold, abandoned, or given away;
- Watercraft and Aircraft;
- Uninsured or underinsured motorists;
- Intentional injury or damage
- Punitive damages
- Nuclear hazard or Pollution;
- War.

COMMON CONDITIONS UNDER AN UMBRELLA POLICY

The following are representative of conditions included in most umbrella liability policies:

- Notice of occurrence in writing;
- Companies right of appeal at its own expense;
- Loss payable condition.
- Legal action against the company;
- Other insurance conditions
- Maintaining the underlying insurance condition
- Right to recover payment or subrogation clause
- Changes or waivers must be in writing;
- Cancellation stipulations;
- Separation of insured's condition;
- Bankruptcy or Insolvency continued protection conditions.

IMPORTANT DEFINITIONS TO KNOW

Aggregate limits are the overall limits of insurance that will be paid during a specified policy period.

Assumption of Risk is the willing and knowledgeable exposure of oneself or property to the possibility of injury. Someone who knows the danger but voluntarily takes the risk.

Attractive nuisance is a structure or artificial condition or artificial condition that is especially attractive to trespassing children and which might result in danger to them.

Avoidable Consequences are consequences that are caused by lack of care on the part of an individual, and that could have been avoided if proper care had been exercised.

Basic Limits are the minimum amount of insurance coverage a policy will provide.

Bodily Injury refers to injury to the body of a person as defined in the policy contract.

Cancellation defines the termination of an insurance policy before the end of the policy period as specified in the policy.

Catastrophe defines an event that causes a loss of extraordinarily large values.

Claim is a demand to recover under an insurance policy for loss.

Claims Made Policy is a commercial liability policy that pays for events occurring during a specified period and for which a claim is made during the policy period, subject to stipulated limitations and extensions.

Commercial General Liability Insurance is a line of insurance available to commercial risks and providing coverage on behalf of the insured for sums they may be legally required to pay to others as a result of the insured's actions or negligence.

Common Law a standard of rules of action arising from usage and customs or from court judgments that recognize and enforce custom. Common law is unwritten and has never been enacted into statue law.

Comparative Negligence refers to the relative degree of negligence by each party involved.

Comprehensive Personal Liability Policy is a policy that provides broad coverage for an individual or family's liability exposure for bodily injury or property damage.

Concurrent Insurance is insurance under two or more contracts, all terms of which are identical except that they may vary in amount or policy date.

Contract is a legal agreement between two or more parties. An insurance policy is a contract.

Contract Law is a type of civil law involving a written or stated agreement between two or more parties for some specific promise of action.

Contractual Liability is assumed in a contract or agreement.

Contributory Negligence is negligence on the part of both parties involved in a suit. If the plaintiff is found to have contributed to the loss the plaintiff cannot collect damages.

Coverage is the guarantee to pay for specific losses as provided under the term s of a policy.

Coverage Territory is the geographic area within which damage must occur in order to be covered.

Coverage Trigger is the event that activates coverage under a certain insurance policy.

Degree of Care is the extent of duty owed by one person to another.

Disability is the inability to carry on one's normal occupation due to injury or illness.

Earned Premium is that portion of the premium that represents coverage already provided.

Employer's Liability Insurance protects an employer against claims for damages which arise out of injuries to employees in the course of work.

Endorsement is an amendment in writing, including printing or stamping, added to, and made part of an insurance policy for the purpose of modifying the original contract.

Excess Insurance is coverage that pays only after other insurance has been exhausted.

Exclusion is anything stated in an insurance policy as not covered by the policy.

Extended Reporting Period applies to commercial liability claims, is a period following policy expiration during which claims may be made or during which the insurer may be notified that an event has occurred that could result in a claim.

Fellow Servant Rule is a common law defense that allows employers to escape liability for injury to an employee if another employee's carelessness had contributed to the loss.

First Named Insured is the individual or organization named first in the Declarations of a policy.

First Named Insured-Commercial Policy has rights and responsibilities not specifically assigned to other named Insureds.

Flat Cancellation is the cancellation of the policy at or before it becomes effective, with all premiums refunded.

General Aggregate is the total limit of insurance coverage in a commercial liability policy that will be paid in one policy year for certain coverage.

Gross Negligence is the failure to use ordinary care or a total disregard for the safety of others.

Hazard is anything that increases the chance of loss.

Indemnification is a principle of insurance, which states that the individual should be restored to the approximate financial position he was in prior to the loss.

Insured is the person or organization covered by an insurance policy.

Insured Contract is a very specifically defined contract that does not invalidate coverage under a commercial liability contract.

Insurer is the insurance company that issues a given policy to provide coverage as specified.

Insuring Agreement is that portion of an insurance policy that expresses the insurer's agreement to provide coverage.

Intentional Tort is a wrong performed by one party with the deliberate attempt to harm another.

Legal Liability is a liability imposed by law, as opposed to a contract agreement.

Limits of Insurance is the greatest amount of insurance a policy will provide.

Negligence is the failure to use the care that is required to protect others from unreasonable chance of harm.

Occurrence is defined in a liability policy as an accident or continuous exposure to substantially the same general harmful conditions.

Occurrence Policy is a commercial policy that pays for events that happen during the policy term, regardless of when the claim is filed.

Per Occurrence Limit is used in a commercial policy to represent the maximum that a policy will pay for losses in a single occurrence.

Personal Injury a harm that comes to a person that is not bodily injury. Things like false arrest, slander, or violation of privacy.

Policy Conditions specify the duties and responsibilities of both insured and insurer.

Policy Declarations is where information is stated regarding who is insured, where and how, all summarized in a single document.

Pollution Exclusion is a commercial liability policy exclusion whereby coverage is denied for most forms of pollution that results in bodily injury, property damage, and cleans up costs associated with pollution.

Prejudgment Interest refers to interest that a claimant requests in addition to the judgment for actual claim. This is based on the premise that earlier awarding of the judgment would have resulted in the claimant having earlier use of the award. Prejudgment interest in not automatically awarded to a claimant.

Primary Insurance is the policy that applies first when two or more insurance policies apply to a loss. Products-Completed Operations Aggregate is the total limit of insurance coverage, in a commercial liability policy, that will be paid in one policy year for losses that fall within the products completed operations hazard.

Products-Completed Operations Hazard is bodily injury and property damage that occur somewhere other than the insured's premises and involves the insured's products or work.

Property Damage is physical damage to tangible property and to loss of use of tangible property, whether or not physically damaged.

Pro Rata Cancellation is the cancellation by an insurance company of a policy before it expires and returning to the policyholder an amount of premium proportional to the unexpired days of the policy.

Proximate Cause is a direct causal relationship between the breach of duty owed to another party and the damage sustained by that party.

Punitive Damages are awards to a plaintiff that punish the defendant for anti-social actions, rather than reimbursing the plaintiff for loss.

Renewal is the reinstatement of an insurance policy beyond the original expiration date, either by endorsement, certificate, or a new policy.

Retention Limit is the amount the insured must pay for a loss not covered by an underlying policy before the umbrella begins to cover losses.

Retroactive Date is a date stipulated in the Declarations as the first date on which an event may occur and be covered by the policy if a valid claim is filed.

Short Rate is a method of figuring the return premium when a policy is cancelled by the insured. A portion of the unearned premium is kept by the company for expenses.

Strict Liability is liability that arises from deliberately pursuing actions that are potentially hazardous.

Subrogation is the transference to the insurance company of the insured's rights to collect damages from another party.

Supplementary Payments refers to payments that may be made to the insured in addition to the payments made for the coverage provided.

Tort is a civil wrong, not arising from a contract, but from which money damages may be incurred.

Ultimate Net Loss is the amount the insured is legally obligated to pay as damages for a covered claim or suit. The amount usually includes deductions for recoveries and salvages. The amount does not usually include expenses in connection with defending the claim or suit.

Umbrella Liability Policy is a policy that provides broad coverage for an insured liability over and above liability covered by underlying contracts or retention limits.

Unearned Premium is that portion of the premium that covers the unexpired part of the policy term.

Vicarious Liability is negligence that is not directly attributable to the person claimed against, but to another for whom the person claimed against is in some way responsible.

Watercraft Endorsement is an add-on to the Homeowner's contract that provides coverage for watercraft that is excluded under the base policy.

CHAPTER 2: UMBRELLA POLICY BASICS

THE NEED FOR UMBRELLA POLICIES

There are many situations where a standard liability policy is simply not enough coverage. An umbrella policy allows an individual to protect themselves against major lawsuits in two ways:

The umbrella provides excess liability over underlying coverage;

The umbrella provides liability coverage that may be excluded by homeowner or auto policies.

Often referred to as a *personal catastrophe policy,* a personal umbrella policy, supplements the basic personal liability coverage provided under homeowner and auto policies. The umbrella was created to protect people from large losses.

Special Protection

Personal injury losses that may be limited or excluded under most homeowner policies will receive broader coverage under an umbrella policy. As a rule, personal injury does not have a uniform definition; however, most umbrellas will refer to personal injury to include bodily injury. Most policies also include in the definition of personal injury:

Mental anguish, false arrests, wrongful eviction, wrongful detention, malicious prosecution, invasion of privacy, assault and battery, slander, libel, and defamation of character.

Standard Policies and Variations

There is no standard personal umbrella policy. The insurance coverage, as well as the exclusions, will vary by company. It is important to compare the costs against the coverage the policy provides. In some cases, it is more important to know what is *excluded* from coverage. Additionally, investigate what coverage and limits are required on the underlying homeowner and auto policies.

Coverage

GENERALLY, AN UMBRELLA POLICY PAYS ALL OF THE COVERED LOSS THAT EXCEEDS THE limits of the base or underlying policy. If, for example, the basic policy paid $200,000 for a slip and fall injury and the claim was for $250,000, the umbrella would cover the $50,000 over the basic policy's $200,000 limit.

Deductible

Usually umbrella liability policies have two types of deductibles. These are also referred to as *retained limits*. Depending on the loss, one of them pays first before the umbrella pays. If the loss is covered by the underlying policy, that policy pays first up to its maximum limit and then the umbrella policy coverage are applied.

Another consideration is that a loss may occur and is covered by the personal umbrella but not by an underlying policy. In this case, the insured must meet a deductible that is referred to as the SIR, which stands for Self-Insured Retention. For example, a $1 million umbrella usually has a $250 SIR that the insured must pay before the umbrella coverage is applied.

Other Exclusions

Typically, the umbrella policy excludes losses that are better covered under other policies. Although there are differences, most umbrellas will not cover the following:

Obligations under workers' compensation or similar laws

If a domestic employee is injured, coverage is afforded under workers' compensation and will not be duplicated under the umbrella policy.

Damage to property owned by the insured

This precludes any coverage for property damage best insured under some form of property (homeowner) or inland marine (jewelry floater) insurance.

Damage to property on which an individual agreed to provide insurance

The intent is to prevent the insurance company from paying for a loss that should be insured under some form of property insurance, especially since the insured has agreed to provide coverage.

Disability arising out of a business pursuit

If a homeowner policy covers some business pursuits (e.g., an office at home), the umbrella will also extend coverage. Some policies also provide coverage to persons who are involved in civic activities, other than a person's regular employment, which may prompt lawsuits.

Liability arising from rendering (or failing to render) professional services

This typically excludes malpractice, which is better covered by malpractice insurance.

Liability arising from the ownership, maintenance, or use of any aircraft

Such potentially catastrophic losses are excluded.

Liability arising from the ownership, maintenance or use of watercraft not covered under the homeowner policy (subject to certain restrictions)

The umbrella covers small boats that are typically afforded coverage under the homeowner policy; however, large watercrafts are excluded because of the increased liability risk.

Liability covered by a nuclear energy policy

Nuclear energy policies contain a person's insured or "omnibus" clause that encompasses virtually everyone who may be responsible for a nuclear accident, barring only the U.S. government. If a person should become involved in a nuclear incident covered by a nuclear energy policy, such a person would be covered by that policy and would not need protection under the umbrella. Therefore, coverage is excluded under the personal umbrella policy.

CHAPTER 3: RISK MANAGEMENT

THE PROCESS OF RISK MANAGEMENT

Different individuals handle risk differently. Past personal experience typically determines how an individual will respond to uncertainty. Before determining the best way to handle a risk, an individual must identify risk probability and severity. This is referred to as risk management. It is the process of:

- Determining what exposures to loss exist;
- Determining the seriousness of exposures; and
- Developing a way of minimizing the effect of the loss exposure.

The goal of risk management is to make the best possible arrangement ahead of time so that serious financial harm does not result when a loss occurs. Risk management is intended to protect income and assets against unforeseen, unintended, or accidental loss.

A risk manager follows five basic steps in the risk management process:

- Identifies the loss;
- Evaluates the exposure and eliminates the severity and frequency;
- Selects the most economical way of handling the risk;
- Formulates a risk management plan;
- Revises and monitors the risk management plan.

Identifying the Loss

Before risk can be managed it is necessary to *identify* all the possibilities of loss or the loss exposures to which an individual is subject and which can be guarded against in some way.

The term *loss exposure* is used to describe the property or person facing a condition in which loss is possible and unpredictable. Potential property losses include direct and indirect losses; potential liability losses are those associated with torts or, to a much lesser extent, breach of contract.

Property Loss Exposures

The individual risk manager begins the risk management process by compiling an inventory of all real and personal property, indicating the amount of property owned and its present value.

Real property consists of land and, generally, whatever is erected or growing upon or affixed to it. The definition of real property includes the earth's surface, the air above and the ground below, as well as all appurtenances to the land, including buildings, structures, fixtures, fences, and improvements erected upon the land.

Excluded are growing crops. The term also includes the interests, benefits, and rights inherent in the ownership of real estate.

Personal property consists of tangible, movable possessions and includes things such as furniture, jewelry, automobiles, and recreational vehicles. After the inventory is complete, the risk manager can identify the possible property loss exposures that should be addressed.

The possible causes of property losses that should concern property owners are numerous. Two basic types of risk that may cause financial loss may classify these losses. These risks include:

- ❖ Direct physical damage to property caused by perils such as fire, wind, water, and other perils that may damage or destroy the property;
- ❖ Indirect loss that occurs following a direct loss to property by an insured peril and that includes additional loss expenses for the extra cost of food, transportation and housing incurred by the insured.

Property may be damaged or destroyed by *physical perils*, such as fire, smoke, explosion, hail, etc. Deviations from expected individual conduct, such as theft, vandalism, or arson, may be termed *social perils* that cause property loss.

Finally, certain *economic perils*, which occur less frequently, may result in property loss. For example, people protesting a factory layoff may cause damage to nearby property. Two or more perils, such as fire and vandalism, may be involved in a loss.

Liability Loss Exposures

The term liability is used in a number of ways. Generally, the term is synonymous with moral or legal *responsibility* and involves the concept of facing a penalty when a particular responsibility is not met.

Legal liability is defined as the condition of being bound in law to do (or not to do) something that may be enforced in the courts. The law does not recognize moral responsibility alone as legally enforceable, but people who do not meet their moral responsibility may also become legally obligated to pay for another's injuries.

Under our legal system, a person may be held responsible for causing injury to another person or damage to another's property. People are faced with the possibility of having to defend themselves against a lawsuit, even if the suit is groundless.

The risk of being held financially responsible for judgments, legal defenses, and court costs, as well as the indirect expenditures of time, energy, and money, is the greatest risk that most people face. Therefore, in addition to property loss exposures, risk managers must identify two basic types of *liability loss exposures*:

Casualty loss that results from perils such as robbery, burglary, vandalism, or arson; and

Liability risk where the law of negligence is used as the basis to determine whether an individual may be held responsible for the financial cost of other people's bodily injuries or for damage to their property.

An individual may incur liability loss exposures in a number of ways. An individual may be held legally responsible for injuries or damages that result from:

- ✓ Ownership of an auto, recreational vehicle, watercraft, or residence premises;
- ✓ Personal or business activities; from obligations assumed under a contract;
- ✓ The employment of domestic workers; from libel, slander, and other personal injury offenses;
- ✓ A number of other events;
- ✓ Individuals may be held criminally or civilly liable, depending on the nature and form of their actions.

Criminal liability is clearly established by statute or administrative rules. In a criminal action, a district attorney or attorney general of either the state or federal government initiates the criminal action against the accused wrongdoer. For example, a district attorney will file charges against an accused murderer. If the accused is convicted, the state or federal government imposes penalties.

C*ivil liability* is established by statutes, administrative rules and prior court decisions that outline the rights of the parties, as opposed to each other. One party against another party for the wrongs alleged normally brings a civil liability action. These legal actions are brought by the litigants at their own expense (with the court costs usually imposed on the losing party). The sources of civil liability are classified as those arising from:

- Contractual or similar agreements;
- *Torts*, which are acts or omissions other than breach of contract;
- *Equitable actions* such as fraud, errors, or mistakes;

Actions that do not fall into the first three categories. Remedies based on contractual agreements and tort actions seek monetary damages; those based on equitable actions usually seek some other remedy, such as performance of a contract.

Evaluating Loss Exposure

In the second step of the risk management process, the risk manager must evaluate the loss exposures and decide which risks are intolerable, which are difficult to tolerate and which are tolerable.

Intolerable risks are those that are so large that a loss from one might cause a person's bankruptcy. These risks typically include liability risk and the risk of the destruction of a home because of a natural disaster.

Difficult to tolerate risks are those that would cause the individual a significant financial loss but that would not lead to bankruptcy. An example would be the destruction of an automobile.

Finally, t*olerable risks* include loss or damage to personal property that might be large but are not intolerable in terms of the individual's finances. An example would be replacement of a broken windshield.

Having identified the risks, the risk manager then estimates both the maximum possible loss and the maximum probable loss the property owner faces. These two estimates are useful in determining the best way or ways to handle a loss exposure. The *maximum possible loss* is the worst loss that could *possibly* happen, while the *maximum probable loss* is the worst loss that is *likely* to happen.

For example, it is possible for a house located in Arizona to be completely destroyed by flood; however, it is unlikely that such a loss will occur. Therefore, if a house is not located in a flood area, it is usually unnecessary (and sometimes impossible) for the insured to purchase flood insurance.

After the risks have been classified in this way, the risk manager then evaluates the frequency and severity of each loss.

Frequency is a measure of how often a particular event has occurred; *severity* is a measure of the damage caused by each incident. For example, counting the number of times a person's dog has bitten a neighbor is a frequency measurement, but calculating the medical and legal costs of those bites is a severity measurement. After this step has been completed, the risk manager can decide how to effectively deal with his property and liability loss exposures.

HANDLING THE RISK

The risk manager may select one or more risk management techniques to handle the identified risks.

These techniques include avoidance, retention, loss control, non-insurance transfer and insurance. When considering which of the risk management techniques to implement, the risk manager considers three general, practical rules of risk management:

- The size of the potential loss must relate favorably to the resources of the one who must bear the loss;
- The possible benefits of taking a risk must be reasonably related to the possible costs;
- The amount of potential loss can usually be reduced or prevented through effective loss control programs;

The risk manager must determine whether it is best to reduce, eliminate or transfer the risk.

Selecting a technique begins by using information gathered in the second step of the risk management process.

The risk manager has approximated the total loss from one event, or *occurrence*, and has estimated how often a particular loss is likely to occur (*loss frequency*) and how much could be lost if a certain event should occur (*loss severity*).

For example, if a homeowner is estimating the potential loss frequency and severity of a fire, the following losses are possible:

- ✓ Direct fire and smoke damage to the house and its contents;
- ✓ Indirect damage in the form of burn injuries to a visitor in the house;
- ✓ Damage to neighboring property if the fire spreads;
- ✓ Loss of use of the property because the fire damage makes it necessary for the homeowner to move to another location, at least temporarily.

The risk manager should determine the probability and possibility of each type of loss, as well as the loss of frequency and severity of those losses.

Then, the risk manager must determine the amount of money that will be available to cover the potential loss. This amount will vary widely by individual. To find out how much a person is worth requires completion of a personal balance sheet. This is a financial inventory of all personal *assets* (that which is owned) and liabilities (that which is owed). The difference between assets and liabilities is a person's *net worth*.

The balance sheet provides an individual with a record of his financial progress and can help with future savings and investment programs. By determining net worth on an annual or semiannual basis, it is possible to verify whether net worth is increasing, decreasing, or remaining the same, and if the net worth is keeping pace with the rate of inflation. It is also possible to determine what portion of assets can be converted into cash in the event of a property or liability loss and a need for cash to pay for the loss.

Finally, the benefits and costs of any available alternative method of handling the risk in certain situations must be considered. In many cases, insurance is the answer; however, other risk management techniques, such as loss prevention or self-insurance, may also be viable options under various circumstances.

IMPLEMENTING A RISK MANAGEMENT PLAN

The fourth step of the risk management process is executing the plan that the risk manager has devised. Insurance coverage, which is the focal point of most individual plans, is usually purchased. The risk manager's objective is to purchase policies that will provide the most comprehensive coverage at the most reasonable cost. Insurance contracts will be one of three types:

Primary insurance required by law (e.g., automobile liability insurance) or by contract (e.g., homeowner insurance required under a mortgage contract);

Desirable insurance that provides protection against losses that could financially harm an individual but that would not completely destroy his savings (e.g., physical damage insurance protects against damage to the insured's auto); and

Catastrophic insurance that provides protection against losses that could financially destroy an individual (e.g., flood, earthquake and personal umbrella liability insurance provide protection against devastating losses).

The risk manager selects limits of liability that adequately cover the risk's probable maximum loss, as well as reasonable deductibles that help to reduce the annual premium for insurance coverage. Because some of the risks faced by the individual may not be insurable, these risks must be handled in some other way.

For example, war risk is not covered by insurance so individuals must retain that risk. In other words, if property is damaged or destroyed by an act of war, property owners must pay for the loss themselves.

Monitoring the Plan

The final step in the risk management process involves a well-planned program for monitoring and updating the original plan. This consists of regularly identifying any changes in the risk manager's loss exposures, net worth, ability to personally bear financial losses and so forth. All of these are especially important considerations for individuals. Risk management as a process grew out of businesses' insurance management, but insurance is hardly the sole method of treating risk.

There are various alternative methods. For example, as a person's net worth increases, there is a greater need for more insurance to protect the possible financial cost of losses to that property, the loss of use of that property and additional expenses that could arise from such losses. However, increased wealth might mean that an individual feels comfortable retaining more losses and may, therefore, take a larger deductible to reduce the cost of his insurance premiums.

When an insurance agent participates in the risk management process with a client, he/she assumes important responsibilities. The client looks to the agent as a professional who can provide sound advice and, when necessary, can collaborate with other experts in applying the principles of risk management.

When insurance protection is necessary for transferring a risk, the agent will be expected to propose a practical and effective insurance plan that provides proper coverage in the correct amounts to offer adequate protection at the most reasonable cost.

Primary Insurance Policies

The average person selects insurance, with some retention in the form of a deductible, as his primary risk management technique. Most people will purchase a homeowner and/or a personal auto policy to cover their loss exposures. The policies are referred to as *primary, basic,* or *underlying* insurance policies.

Although various homeowner and personal automobile forms are in use, most follow a format similar to the programs developed by the Insurance Services Office (ISO).

Handling Liability Loss Exposures

Most people handle the risk of legal liability arising out of their personal acts with *personal liability insurance*. Because liability losses involve a third party, a determination of fault must be made by the insurance company or the court.

In the event of a lawsuit involving bodily injury or property damage to another person, the insurance company will provide a legal defense and will pay those sums the insured is legally obligated to pay, up to the limits of the policy. *Bodily injury* refers to bodily harm, sickness, or disease, including injuries that result in death.

Coverage also applies for any required care or loss of services of anyone whose bodily injury is negligently caused by the insured.

For example, under common law, a husband may be entitled to monetary compensation if his wife is injured in an accident and unable to provide certain duties owed to her husband under the marriage contract. These duties are collectively called *consortium* and the spouse may be compensated for *lack of consortium*.

Additional coverage called *property damage* coverage applies to damage to or destruction of tangible property, including the loss of such property.

Personal liability insurance may be purchased as a separate policy or, more commonly, it is provided as part of a package policy, either an auto or a homeowner package. Because these liability coverage are quite similar, we will primarily discuss the homeowner liability coverage.

The liability section of the homeowner policy protects the insured in at least two ways:

If a claim is made or a lawsuit is brought against an insured, the policy will pay for damages for which the insured is found legally liable, up to the policy's limit of liability, typically $100,000 per occurrence. Higher limits may be obtained for an additional premium.

Typically, coverage will apply for claims arising out of the ownership or use of the insured location; personal activities, such as sports or social activities on or away from the insured premises; and actions of a residence employee, such as a cook, housekeeper, nanny, or baby sitter, in the course of employment.

In addition to the limits of liability, the insurance company must defend any claim or lawsuit that is brought against the insured for bodily injury or property damage - even if the claim is false, baseless, or groundless.

In some cases, the policy specifies that the insurer's obligation to settle or defend claims ends when the amount the insurer pays for legal defense equals the policy's limits of liability. As a practical matter and to avoid expensive litigation, most personal liability lawsuits are settled out of court.

Individuals who own or operate automobiles may purchase liability protection in the form of an automobile policy. The Personal Auto Policy, for example, includes Part A - Liability Coverage, which provides protection against economic loss to an insured for "bodily injury" or "property damage" that arises out of the operation, maintenance, or use of an insured automobile.

Under this policy section, the insurance company makes two promises to the insured:

- ✓ To pay damages on behalf of the insured for which he becomes legally responsible because of an accident; and
- ✓ To settle or defend any claims under the policy, up to the policy's limit of liability.

It is important to note that the insurer has no duty to defend lawsuits or to settle any claims that are not covered under a particular insurance policy.

For example, an insurer who provides automobile or homeowner insurance is not required to defend an insured who is sued by a neighbor for intentionally using a motor vehicle to damage the neighbor's lawn because intentional damage is not covered.

Personal Injury Liability

The personal liability provided under the ISO homeowner policy specifically covers two types of liability:

- ✓ Bodily injury, meaning bodily harm, sickness, or disease, including required care, loss of services, and death that results; and
- ✓ Property damage, meaning physical injury to, destruction of, or loss of use of tangible property.

The policy does not mention coverage for personal injury losses meaning any injury to another's person, rights, or reputation, including torts such as libel, slander, or invasion of privacy. Many insurers contend that they did not intend to provide coverage for personal injury liability under a standard homeowner policy and coverage is often denied on that basis.

When coverage is not provided by the homeowner policy itself, a personal injury endorsement may be added to the policy to provide coverage for certain offenses committed during the policy period. The ISO personal injury endorsement does not provide coverage for liability:

- ✓ Arising out of disputes between insureds;
- ✓ From contracts not related to the premises;
- ✓ From the injured person's employment by the insured;
- ✓ Involving a violation of a penal law;
- ✓ Arising out of business pursuits;
- ✓ Arising out of civic or public activities performed for pay.

Personal injury liability protection may also be extended by a personal umbrella liability policy.

THE STRUCTURE OF PRIMARY POLICIES

Property-casualty policies usually contain the same policy elements, regardless of what type of property or liability coverage they provide. Each policy begins with a Declarations page that contains information found on the client's application for insurance and any information that is unique to that particular policy.

A Declarations page usually contains the name and mailing address of the insured(s), the name of the insurance company providing coverage, the policy number, the inception date and expiration date of the policy, the dollar amount of the applicable policy limits and deductibles, the numbers and edition dates of any forms and endorsements and the premium.

Policies usually contain a separate Definitions section that explains the meaning of certain words that are used in the insurance contract. The defined words may appear in boldface type, italics or within quotation marks.

For instance, this section often explains that throughout the policy the named insured is referred to as "you," "your" and "yours" and the insurance company is referred to as "we," "us" and "our."

If a word is not defined in the Definitions section or in the body of the policy, rules of contract interpretation are used to determine the meaning. For example, technical words are interpreted according to their ordinary technical meaning and legal words are assigned their usual legal meaning.

The policy's Insuring Agreements provision sets forth the insurance company's promise to pay the insured (or to pay on behalf of the insured) for a covered loss. In return for the insurer's promise, the insured must pay a premium and comply with certain policy requirements, which are spelled out in a section called Conditions.

The Conditions section states that the insured must, in addition to paying a specified premium, report losses promptly, cooperate with the insurer in settling a loss and avoid anything that might harm an insurer's right to recover damages from a responsible third party. If the insured fails to comply with these conditions, the insurer may be relieved of its obligation to pay for the loss or defend a lawsuit.

Policies also contain a number of coverage exclusions that restrict or eliminate insurance coverage for specified loss exposures. These exclusions appear throughout the policy as well as in a separate section called Exclusions.

Finally, some policies may contain various amendments or Endorsements to the basic policy provisions, which must be issued by the insurance company or its duly appointed agent.

CHAPTER 4: IDENTIFYING THE NEED FOR UMBRELLAS

LIABILITY ISSUES

People can be held legally liable to pay damages for the bodily injury or property damage caused by their negligence. The need for liability can arise as a result of a person's personal or recreational activities as well as a person's business. Some of the higher liability claims arise when insureds are entertaining guests or permitting people to use their property.

Consider how a jury's desire to punish a negligent person could result in a judgment for damages in the following situations:

- A practical joke misfires and results in a lawsuit for defamation of character.
- A neighbor or guest falls on a person's property, resulting in permanent disability.
- A protective watchdog proves that his bite is even worse than his bark.
- A person's child accidentally breaks an expensive vase while at another person's house.
- A moment's inattention while driving results in a multi-car accident.
- A spark from burning leaves starts a fire that inadvertently burns a neighbor's roof.
- A letter to the editor triggers a libel suit.

Coverage and Liability

It is important to make a distinction between two terms frequently used in liability suits: coverage and liability.

The word coverage refers to the contractual obligation imposed on the insurance company that agrees to indemnify the insured for sums he or she becomes legally responsible to pay as damages. Liability refers to the legal responsibility of the policyholder to other persons arising out of an occurrence. In some cases, a particular peril will not be covered by the policy and the insurance company is under no contractual obligation to indemnify the insured.

For example, assume the insurer issued a homeowner policy covering an insured's liability arising out of the ownership of a certain property. The insurer is under no obligation to provide coverage under that homeowner policy for an automobile accident that occurred away from the residence premises even if the insured was at fault. In this case, there may be liability on the part of the insured, but there is no coverage provided under the policy.

There may be coverage under the policy but no liability on the part of the insured. For example, the Personal Auto Policy provides coverage for property damage up to the policy limits.

However, if the insured vehicle is stolen and the thief uses the car to damage several lawns in the area, the insured has no liability for the damage. Even if the insured feels sorry for the neighbors and perceives some moral obligation to repair their lawns, he has no legal liability to do so. Likewise, the insurance company has no responsibility, either by way of settlement or as a gift, to make any payment to the neighbors.

In this case, while three may be coverage under the policy, there is no liability on the part of the insured.

Insureds should be cautioned that even when there is no apparent liability on the part of the insured or available insurance coverage, the insured may still be sued and found legally responsible.

In a civil case, it is possible that the plaintiff, who must establish his claim by a preponderance of evidence, may produce evidence that is more credible and convincing than that of the defendant's. And, if the plaintiff's case is more believable, the plaintiff will win. The settlement the plaintiff receives might be quite substantial because of three factors:

- The public's attitude toward claims;
- The application of the law of negligence; and
- The jury's opinion about damage awards.

IDENTIFYING GAPS IN LIABILITY COVERAGE

Insureds may believe that policies cover every possible loss exposure, but this is simply not the case. When a liability loss occurs, insureds may be surprised to learn that there are serious holes, or gaps, in their insurance coverage. As stated earlier, an insurance policy covers the insured only up to its liability limits; beyond these limits, a liability insurance policy does not protect the insured.

The majority of policies covering liability for bodily injury have two limits, a limit of liability for one person and another limit (generally higher) for any single occurrence, where more than one person is involved.

For example, assume an insured has a Personal Auto Policy that covers him up to a $300,000 liability limit for bodily injury for each accident or occurrence. If the insured is involved in an accident and is held liable for $200,000 in bodily injury damages, the auto policy will pay for those damages.

However, if the insured is held liable for damages in excess of $300,000, he or she will be held personally liable for the additional damages.

The underlying personal liability insurance, in addition to paying only up to certain limits of liability, excludes certain loss exposures. For example, the liability portion of the homeowner policy does not cover the following:

- Damage from the intentional acts of the insured,
- Damage caused by the rendering or failure to render professional services,
- Damage from acts of war;
- Damage from communicable diseases;
- Damage arising out of business activities.

In addition, not all individuals on the insured's property or in the insured's auto are afforded coverage by the insured's primary liability insurance.

Residence employees, defined as employees of the insured whose duties are related to the maintenance or use of the residence premises, including household or domestic services, may not be covered under the liability section of the homeowner policy if the insured is required to have workers' compensation coverage in force for such employees.

The basic Personal Auto Policy excludes liability coverage for:

- Damage caused by intentional acts of an insured,
- Damage to property owned by, rented to, used by or in the care of an insured,
- Bodily injuries to employees covered under workers' compensation.
- Damages resulting from the ownership or operation of a vehicle while it is being used as a public or livery conveyance; and
- Damages incurred while a party is employed or engaged in the business of selling, repairing, servicing, storing, or parking vehicles.

Finally, underlying policies generally do not provide liability coverage for unusual loss exposures or for losses that occur outside the United States. For example, the Personal Auto Policy limits coverage to accidents and losses that occur within the policy territory, meaning the United States of America, its territories or possessions; Puerto Rico; Canada; or while the auto is being transported between their ports.

PERSONAL UMBRELLA POLICIES

The Personal Umbrella Liability Policy was created to expand the insured's liability coverage by filling gaps in the basic liability coverage provided by underlying policies and to reduce the insured's worry, trouble, and burden of facing personal litigation on his own.

Personal umbrella liability coverage usually is sold in units of $1 million or more and may be added to a basic homeowner or auto policy that is already written by the insurance company. Many companies also write stand alone or separate, personal umbrella policies without writing the underlying coverage.

To qualify for stand-alone coverage, however, the applicant is usually required to show proof of certain underlying insurance coverage with other insurance companies. Umbrella policies provide insurance for accidents and other situations not ordinarily covered under primary insurance, subject to a deductible of between $250 and $1,000.

There is no standard personal umbrella liability policy. The policy's forms, format and coverage vary by insurer. This does not necessarily mean that because one company's policy looks more extensive that it is superior to another policy.

Rather, each contract should be reviewed to determine which offers the best coverage for a particular policyholder. Regardless of which company is providing the policy, all personal umbrella policies are designed to give insureds and their families two types of extra liability protection.

They add to the liability of any homeowner, automobile, or other liability policies currently in force. Most homeowner policies provide basic personal liability coverage of $100,000; auto policies typically contain a combined single limit of $300,000 per occurrence.

- An umbrella policy supplements this basic personal liability coverage. If, for example, the insured has a standard auto policy with liability limits of $300,000 and a personal umbrella policy with limits of $1 million, the insured is protected up to $1,300,000, if a covered auto accident occurs and the insured is found legally responsible.

They are designed to cover liability exposures that other policies do not cover. The personal umbrella policy is designed to cover some of the more unusual exposures, such as personal injury claims, that an insured might face but that are typically not covered under most standard liability policies.

There is Difference in Conditions (DIC) insurance, a property coverage that expands insurance written on a named perils basis to an open perils basis and protects the insured against risks of direct physical loss to the insured property, subject to certain exclusions and deductibles.

An umbrella contract provides (subject to a deductible) liability coverage where no other liability insurance exists, and in addition provides coverage for liability when the limit of the primary or underlying insurance has been exhausted.

Special Characteristics of Umbrella Policies

The insurance company that issues the umbrella policy provides additional liability coverage over the primary policies, up to the limits listed on the Declarations page of the umbrella policy, even if the same insurer does not provide the underlying insurance. The personal umbrella policy covers any number of accidents or occurrences that occur during the policy term, regardless of how many claims are presented.

However, the policy restricts payment for any one accident to the limit listed in the policy (usually up to $1 million per occurrence). In other words, even though the insurer may pay for ten claims totaling $10 million during a one-year period, it will not pay more than $1 million for any one occurrence.

To limit the insurer's liability, however, many umbrella policies are beginning to offer aggregate limits, meaning a maximum dollar amount that may be paid during the policy period or during the insured's lifetime, as specified in the policy. A policy with a $10 million aggregate limit, for example, may pay several claims for $1 million each, but it will only pay out a maximum of $10 million during a given policy period.

It is important to remember that the personal umbrella is a third-party liability policy that covers only another person's claim against the insured. It does not cover damage to the insured's own property, motor vehicles, home, or other valuables.

CHAPTER 5: BASIC POLICY COMPONENTS

PERSONAL UMBRELLA LIABILITY POLICIES

The insurance industry has developed a number of liability contracts over the years to meet the basic liability exposures of individuals and businesses. More than thirty years ago, in the 1960's, personal catastrophe liability contract (or as it is more commonly called a personal umbrella liability policy) was developed.

The contract was originally aimed at insurance buyers with the idea of providing broader insurance protection for individuals, especially professionals and wealthy members of society, who were excellent targets for liability lawsuits that could result in significant claims. Today, however, it is not unusual for liability claims to exceed the basic limits of liability afforded by an average insured's homeowner or auto policy.

These claims, which may result from personal activities or professional or business pursuits, are usually covered by a personal umbrella liability policy.

There is no standard personal umbrella liability policy form or format. Each insurer develops its own policy based on its own preferences and/or the needs of its clients. Because coverage varies by insurer, it is important for the insurance producer and his client to examine each personal umbrella policy to make sure that it is not merely an ordinary excess liability contract.

An excess policy provides only additional layers of coverage to the coverage already furnished by the underlying policy. The terms and conditions of an excess policy should be precisely the same as those of the underlying policy.

A true umbrella policy, on the other hand, provides not only excess liability but also responds to claims that may be excluded in the underlying policy but are not excluded under its own form.

Personal umbrella liability insurance is intended for catastrophe-type claims; an umbrella insurer is simply not interested in covering small claims. To support this intent, personal umbrella policies that cover loss exposures that are not covered by the underlying policies are subject to deductibles commonly referred to as retention or self-insured retention.

Most insurers offer minimum deductibles of $250 but offer higher ones for additional reductions in premium. In some cases, an insurance underwriter will require a substantial deductible when a particular risk is not otherwise insurable because of some unusual exposure to loss.

In general, the purpose of a personal umbrella policy is not only to provide million dollar-plus excess limits but also to broaden basic liability protection in several ways. In most cases, the personal umbrella liability policy is intended to:

1. Apply worldwide coverage (where permitted by law), without territorial restriction, as is the case with most primary insurance coverage;
2. Provide liability coverage for the insured who uses certain non-owned automobiles, watercraft, and aircraft when this coverage is excluded under Section II of the homeowner policy;
3. Include coverage for liability assumed by the insured under certain oral or written;
4. Cover a broad range of personal injury hazards such as libel, slander, false arrest, humiliation, defamation of character, false imprisonment, wrongful eviction, wrongful provide payment of defense costs when primary insurance does not apply.

To adequately protect the insured, a personal umbrella liability policy should serve three purposes:

- It should add an additional amount of liability coverage above the limits provided by the insured's homeowner, personal auto, or other underlying policies;
- It should provide insurance coverage for some exposures that are not covered (or only minimally covered) by the insured's underlying policies; and
- It should provide protection for the insured against certain catastrophic liability losses that might otherwise cripple the insured financially.

THE POLICY STRUCTURE

Depending on the preferences of the insurance company, the actual format of the personal umbrella liability policy will vary among companies. In addition, the amounts and types of coverage may also vary.

Regardless of how it looks or exactly what it covers, however, a personal umbrella policy will usually contain six basic components or policy provisions that outline the details of the contract between the insurer and the insured.

Declarations - This part identifies the parties to the contract and defines who and what the policy insures and for what period of time. The premium and amount of insurance are also stated in the Declarations.

Definitions - The contract's commonly used words and phrases are defined in this section to reduce any misunderstandings between the parties about what the insurer intends to cover.

Insuring Agreements - An umbrella policy contains a number of promises and specific obligations assumed by the insurance company, including its duty to pay certain losses on behalf of the insured. In addition to an introductory insuring clause, there may be several additional statements within the body of the policy that must be referenced when a loss occurs to determine both the insured's and the insurer's responsibilities.

Conditions - This policy provision describes the policy requirements with which the insured must comply before the insurer is obligated to pay.

Exclusions - This provision specifically lists causes of loss for which the insurer does not intend to provide coverage.

Miscellaneous Provisions - Some policy provisions, such as the insured's duties when a loss occurs, do not neatly fit into the Declarations, Definitions, Insuring Agreement, Conditions or Exclusions headings. These provisions may be grouped together as Miscellaneous Provisions.

Declarations Page

The preliminary section of each umbrella liability policy contains a Declarations page (also called a dec page or the dec) that contains pertinent information about the insurance risk, on the basis of which the policy was issued. The insurer, which draws up the insurance contract, is expected to clearly represent the intent and terms of the policy.

Therefore, the purpose of the Declarations page is to provide information about who is covered (the named insured), what is covered (the property and perils listed in the policy), when it is covered (the effective dates of coverage), where it is covered (the described location) and why it is covered (a premium has been paid) so that there is no ambiguity.

The entire policy, including any endorsements or changes to the policy, is inserted into a policy jacket that serves the same function as the covers of a book. The policy jacket keeps the Declarations page and all the policy forms in one place, thereby allowing the insured to easily find, read and review his insurance policy.

Insuring Agreements

Every umbrella liability policy contains an insuring clause that is a general statement of the promises the insurance company makes to the insured. In addition to this general clause, the policy often contains a number of other guarantees referred to as Insuring Agreements. These Agreements state what the company promises to do, such as agreeing to defend the insured in a liability lawsuit.

Definitions

In response to complaints from Insureds and the courts that the terms used in insurance policies were not clearly defined, the insurance industry developed a section called Definitions that is now contained in every insurance policy, including a personal umbrella policy.

Personal umbrella liability policy definitions are not standardized. An insurer develops its own definitions and policy wording, which may later be modified by the underwriter to meet the requirements of the applicant or to adapt to unique situations presented by different underlying forms of coverage.

For example, an insurance company's definition of an insured may include the person named in the Declarations page (the "named insured"), the named insured's spouse, any relatives, and persons under a specified age and in the care of any of the persons previously named - if they live in the insured residence. However, another company's definition might specifically remove coverage for any person, other than the named insured, using automobiles or watercraft while engaged in an automobile or boat-related business.

Conditions

Like other insurance contracts, the umbrella policy is a conditional contract. The insured must pay the premium indicated in the Declarations and abide with certain requirements specified in the policy.

The personal umbrella policy's Conditions component describes the rights and duties of both parties to the insurance contract - the insurer and insured. Conditions are provisions inserted in the contract that qualify or place limitations on the insurer's promise to pay for losses. In addition to being contained in a separate section, a policy's conditions may also be found anywhere in the contract where the insurer intends to limit coverage.

Exclusions

A personal umbrella policy does not cover every risk that the insured faces. For example, many insurers will not provide coverage for perils that they consider to be uninsurable, such as war or some other potentially catastrophic event. They also intend to deny coverage under the umbrella if coverage could be better provided by another type of insurance policy or if there are extraordinarily hazardous conditions present.

Finally, insurers exclude coverage for losses that are difficult to measure or for perils that are not needed by the typical insured. Therefore, the personal umbrella policy also contains an Exclusions component that specifically lists causes of loss for which there will be no coverage.

The policy may place limitations on coverage or exclude certain perils or types of losses. Typically, personal umbrella policies exclude the following types of losses:

- ❖ Obligations under workers' compensation, unemployment compensation, disability benefits or similar laws;
- ❖ Business pursuits, professional services and liability resulting from owned or rented aircraft and watercraft excluded under the homeowner policy;
- ❖ Property damage to any property owned by the insured or in the care, custody, or control of the insured;
- ❖ Any act committed by or at the direction of the insured with the intent to cause personal injury or property damage; and
- ❖ Personal injury or property damage for which the insured is covered under a nuclear energy liability policy.

Although these exclusions are fairly standard, additional exclusions may be listed in the policy. In some cases, the insurer allows the insured to "buy back" certain coverage, such as workers' compensation, for an additional premium.

The agent should be familiar with each insurer's exclusions and be careful to point them out to clients so that there will be fewer surprises if a loss occurs that is not covered under the umbrella liability policy.

Miscellaneous Provisions

Some umbrella policies contain provisions that cannot be strictly classified within one of the previous five policy components. These Miscellaneous Provisions might include a discussion of the insurer's production and underwriting rules, its required underlying limits, or any other special company guidelines. In addition, any endorsements that add to, delete, or modify the provisions in the original contract may be included in this section.

An endorsement is an attachment to an insurance policy that is used to clarify, extend or restrict coverage with regard to perils, coverage periods or premiums. It can be a standard endorsement that is used to fit a general situation or it may be worded to fit a particular situation.

These special endorsements are called manuscript forms. When an endorsement is attached to a policy, the endorsement's terms normally take precedence over any conflicting wording in the policy. However, if state law requires any provisions in the policy, an endorsement cannot be used to subvert the intention of the required legislation.

For example, the law may hold a person liable for damages if he or she is found guilty of negligently operating a motor vehicle. The personal umbrella and underlying auto policies cannot be endorsed to delete liability for negligence.

If endorsements are in conflict with a state regulation or law, the laws take precedent and the policy is read and interpreted as if the conflicting endorsements had not been added. In other words, the original intent and coverage are preserved.

REQUIREMENTS OF A LEGAL CONTRACT

A contract is an agreement entered into by two or more parties under the terms of which one or more of the parties, for a consideration, undertakes to do or to refrain from doing some specified act or acts.

In order to be binding on the parties involved, a contract must meet five basic requirements:

- ✓ Offer and acceptance,
- ✓ Consideration,
- ✓ Competent parties,
- ✓ Legal purpose;
- ✓ Legal form (in some cases).

Offer and Acceptance

A contract is in essence an enforceable promise. In order for a valid contract to exist, there must be a valid offer and an unqualified acceptance of that offer, so that the seller understands the buyer's offer and the buyer understands to what the seller has agreed. In other words, a contract begins with a meeting of the minds. The general rule is that it is the applicant for insurance who makes the offer, and it is the insurance company that accepts or rejects the offer.

For example, the potential insured requests insurance and fills out an application for personal umbrella insurance; the application constitutes the *offer*. The agent then *accepts* the offer on behalf of his company.

Assuming that the other requirements for a valid contract are met, the property-casualty agent can usually bind coverage and make it effective immediately. However, the insurer retains the right to investigate, underwrite and cancel the coverage (as described in the policy and in accordance with state law) if the risk does not meet the company's underwriting guidelines.

For example, the applicant may not have disclosed several large liability losses that would have made him ineligible for umbrella coverage with some insurance companies. In this case, the insurance company may decline to offer coverage. In most cases, the agent cannot bind personal umbrella liability insurance.

Consideration

The second requirement of a valid contract is *consideration*, which is the value that each party gives to the other. In the case of an umbrella policy, the insured's consideration is the payment of the first premium (or the promise to pay) and his agreement to abide by the conditions specified in the policy. The insurance company's consideration is the promise to do certain things that are specified in the policy.

This includes indemnifying the insured for covered losses and defending the insured in a liability lawsuit.

It should be noted that the values of the considerations exchanged are not always equal. When the insured purchases a policy, he or she usually pays a relatively small premium in exchange for a comparably large amount of insurance protection. For example, the annual premium for a $1 million umbrella policy might be less than $200, a decidedly unequal exchange of values if a large loss occurs.

In fact, for the benefits the insured receives, a personal umbrella policy may be the best buy in insurance. This relatively inexpensive policy raises the insured's liability coverage to a million dollars or more, and protects him from personal responsibility for damages.

Competent Parties

In order to be legally enforceable, a contract must be between at least two *bona fide* parties. A person cannot make a legally enforceable promise to himself. Thus, John Doe cannot agree to sell a piece of property to himself; however, he could agree to deed the property to himself and his wife as tenants in common.

The parties involved must be legally competent in order to enter into a valid contract. Generally speaking, *competent parties* are adults (usually age 18 or 21, depending on the state) who are able to understand the terms and conditions of the contract into which they are entering. In some states, however, minors as young as 14 may enter into some contracts.

For example, minors have limited ability to contract, which means that the contract of a minor is valid only if the minor does not disavow a contract entered into during his minority or shortly after reaching majority (usually age 18 or 21).

A minor possesses the limited capacity to enter into a valid contract to purchase property from an adult. Such a contract would be enforceable by the minor against the adult, but would be voidable by the minor.

A *voidable contract* is an agreement that for a reason satisfactory to the courts may be set aside by one of the parties to the contract. Contracts made by minors to obtain such necessities as food, clothing, or shelter, however, are not voidable by the minor and will be enforced against him.

Some entities are excluded parties to legally binding contracts. When a person has been adjudicated insane or is an officer of a corporation who is not authorized to execute a contract on behalf of the corporation, he or she has no capacity to contract. Lack of a capacity would also cover acts of a corporation beyond its powers as defined in the articles of incorporation.

Also considered incompetent is any person who is impaired by reason physical or mental disability, drugs, alcohol, age, or any other cause to the extent that he or she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning him.

Therefore, insane and, in certain, intoxicated people are incapable of entering into valid contracts. An illiterate person, however, is not incompetent as long as he understands the nature of his acts.

Legal Purpose

In order to be enforceable, contracts must be made for some *legal purpose.* If the contract does not have a legitimate purpose, it would be contrary to public policy to enforce such a contract. For example, Robert may contract with another person to paint his house for a fee. Such a contract is considered legal and binding.

However, Robert cannot legally contract with another person to kill his wife. Because murder-for-hire is not legal, it is not considered a valid contract and would not be enforceable in a court of law.

Legal Form

Unless otherwise required by laws, oral contracts can be just as valid as written contracts. Generally, however, an insurance contract must follow a specific *legal form* and must be in writing to be enforceable.

All essential terms of the contract must be complete and certain so that the entire agreement is set forth in writing and nothing material to the contract is left to be agreed upon in the future. Once the policy is issued, changes may be made by endorsement, but only if the insurer agrees to the requested changes.

CHAPTER 6: COMMON CONDITIONS

REVIEWING THE POLICY CONDITIONS

Insurance policies are conditional contracts that create a continuing relationship between the insured and the insurance company. In the policy's Insuring Agreement, the insurance company promises to pay on behalf of the insured those sums for which the insured is found legally responsible, to provide a defense for the insured or to furnish other services as stated in the policy.

However, the insurer's promises are enforceable only if an insured peril occurs and if the insured has complied with certain conditions contained in the policy. Insureds understand that they must pay premiums in order to keep their insurance policies in force, but that is not the only thing they have to do. Additional duties are spelled out in the Conditions section of the policy.

As an insurance professional, review insurance policies before they are forwarded to clients to assure that the policies have been issued as requested. Discuss the policy with the client to assure that he understands what is covered and excluded. Be certain the client is aware of his rights and obligations under the contract so he will have fewer problems should a loss occur.

All property-casualty insurance contracts are written subject to certain conditions or prerequisites. The duties of the insured are primarily listed in the Conditions section of the policy; however, other provisions that qualify the otherwise enforceable promise of the insurer may also be found elsewhere in policy forms or endorsements.

An insured should fully understand his obligations under the policy because he cannot expect the insurance company to fulfill its part of the contract unless the insured fulfills all of the required policy conditions.

Failure to do so may release the insurer from its obligations. Most of the policy's conditions have to do with matters such as loss settlements, actions required at the time of a loss, cancellation of coverage and suits against the insurer.

Under most umbrella contracts, Insureds are obligated to:

- ✓ Report losses in a timely manner;
- ✓ Provide any required documentation of losses to the insurer;
- ✓ Cooperate with the insurer in investigating, negotiating, and settling claims;
- ✓ Avoid any action that would risk the insurer's rights to recover from a responsible third party.

Common Personal Umbrella Conditions

Personal umbrella liability policies contain a number of conditions that describe the circumstances under which the contract is to operate. Insureds should understand how these conditions modify, suspend, or rescind the original obligations. In the Conditions section of most policies, the insurer explains that the insured must meet a number of obligations before insurance coverage will apply. For instance, the policy might state:

There are certain responsibilities, which you must fulfill (in addition to paying the premium) as a condition for us to provide coverage.

Policy conditions may be classified in one of two ways: (1) a condition precedent or (2) a condition subsequent.

A condition precedent is a requirement or qualification that must take place before the contract exists. For example, in a contract of insurance, the insured agrees to pay the premium and the insurer agrees to provide certain insurance coverage in return.

The principal duty of the insurer is to provide this coverage, but this obligation is conditioned on the insured's payment of the premium. The failure of the insured to pay the premium (condition precedent) relieves the insurance company of its principal obligation and, in fact, nullifies or voids the contract.

A condition subsequent is a requirement that must be met after the contract is in force. For example, the insured must report all accidents and potential claims to the insurer as soon as possible. A typical clause might read:

In case of a claim or "occurrence" that may be covered by this policy or if a "covered person" is sued in connection with an "injury" or "damage" which may be covered under this policy, the "covered person" must do the following:

- ✓ Promptly notify us or our agent in writing;
- ✓ Promptly send us copies of any notices, legal documents and any other documents that will help us with your defense;
- ✓ Cooperate with us in the investigation, settlement, or defense of any claim.

Assume the insured is involved in an auto accident. The insured feels he was not at fault, so the insurance company is not notified of the accident until a year later when the other driver files a lawsuit.

Because the insured breached the contract by not notifying the insurance company "promptly," the insurer may be relieved of its obligation to defend and indemnify the insured for that particular loss. The insured's failure to comply with this policy condition does not void the entire contract.

The insurer will still respond to other losses during the policy term with the same obligation to defend and indemnify the insured provided the insured complies with the policy's terms and conditions.

The things that an insured or other covered person must do as a condition before the insurance company provides coverage will vary by company. Generally speaking, umbrella insurers will include conditions relating to claims notification, assignment of the policy, cancellation of coverage and legal action against the insurer.

Understanding Insuring Agreements

An insurance contract is an agreement entered into by two parties, the insurance company, and the insured. The contract usually begins with an insuring clause (or clauses) called *Insuring Agreements* that outline the insurance coverage that the company promises to provide in return for the insured's promise to pay a premium and compliance with the terms of the contract. Technically, complying with these conditions is also a part of the consideration.

If a covered loss occurs but the conditions are not met by the insured, the insurer has no obligation to pay. A rather broad Insuring Agreement might read:

"We will provide the insurance described in this policy if you pay the premium and comply with all the terms of the policy."

With this statement, the insurance company (one competent party) enters into a legally binding contract with the insured (a second competent party). Based on the insured's application for insurance (offer) and payment of a specified premium (consideration), the umbrella insurer agrees to provide coverage (acceptance) and issues a personal umbrella liability policy (legal form).

In return for the insured's premium and promise to abide with the terms of the policy, the insurer agrees to assume many of the insured's liability loss exposures. The exact terms of the agreement are specified in the various policy provisions.

Coverage Restrictions

At first glance, Insuring Agreements like the one above might appear to cover every loss exposure. However, because it is unlikely that a company intends to provide unlimited coverage, the insurance producer should look for words or phrases in a policy's Insuring Agreements that might restrict or limit coverage.

In the first example, the words insurance described in this policy are included to warn the reader to look for additional definitions, conditions, exclusions, and miscellaneous provisions throughout the policy that will clarify exactly what the insurer intends to cover under the policy. The policy is not intended to cover every hazard an insured faces. Coverage applies *only* as described throughout the policy.

Insurance companies may include words or phrases in their Insuring Agreements that have a special meaning as used in its personal umbrella policy. This interpretation may be quite different from that normally used by the average person. Many insurers use boldface type, italics, or quotation marks throughout the policy to identify words or phrases that may be used in a special way by the insurer.

An insurance producer or insured that is uncertain about what the insurer intends to cover when a loss occurs will usually find that the intended meaning of a term is explained in the Definitions section of the policy. The definitions are included to reduce confusion about what the insurer expects to cover. For example, the following Insuring Agreements contain a number of accented words.

The company agrees to indemnity the "insured" for "ultimate net loss" in excess of the "retained limit" which the "insured" shall become legally obligated to pay as damages because of "personal liability."

In this case, the insurer wishes to alert the insured that certain words, including *insured*, ultimate *net loss*, *retained limit* and *personal liability*, are used in a way that may be unique to this particular company. The insurance producer and the insured should use the policy's Definitions section to determine whether these terms are used in a way that is familiar to them.

Insured

An *Insured (or covered person)* is defined under most personal umbrella policies as the person named in the Declarations, his spouse and any relatives living in the named insured's household. As mentioned earlier, some companies will limit coverage to relatives under a specified age or require that the named insured have custody of child or stepchild in order for coverage to apply. In many cases, any person insured under the named insured's basic or underlying policies is also covered under the personal umbrella.

ULTIMATE NET LOSS AND RETAINED LIMIT

The intent of an ultimate net loss provision is to limit the insurer's liability to the amount specified in the Declarations less any required retained limits, either specified underlying limits or a retained limit or self-insured retention (a form of deductible). The policy wording will usually explain exactly how and when the insurer intends to make payments under the policy.

A *Retained limit* provision requires the insured to pay some portion of a covered loss before the umbrella policy pays. A retained limit is the larger of:

- The total of the applicable limit(s) of all required underlying insurance required by the insurer and described in the Declarations or elsewhere in the policy and any other insurance available to a covered person;
- Or any deductible required by the insurer or by the state in which the insurer does business.

The insured bears the risk to the extent of the uninsured amount. The retained limit or retention applies on a per loss basis to any loss covered under the umbrella policy but excluded in primary underlying policies. The retained limit does not apply when the umbrella is simply supplementing a primary policy that has exhausted its limits in the payment of a covered claim.

In other words, before the umbrella insurer makes any payment, the primary coverage must pay first or the insured must meet a specified deductible, such as $250 per occurrence. There is a common misunderstanding that there is a gap or space between the primary and the umbrella coverage. No such corridor exists.

In those cases where the insured has purchased the required underlying primary coverage, the protection applies right up to the top collar of the umbrella. In other words, if the insured has the required primary coverage, only that coverage and the umbrella coverage come into play. The insured is not out of pocket for any deductible.

Personal Liability

In most umbrella policies, the term *personal liability* means:

- Bodily injury, sickness, disease, disability, shock, mental anguish, and mental injury;
- False arrest, false imprisonment, wrongful entry or eviction, wrongful detention, malicious prosecution, or humiliation;
- Assault and battery, including death resulting there from.

Many policies also include injury to or destruction of tangible property, including its loss of use.

Example:

To illustrate how an umbrella policy would indemnify an insured for a loss, assume an insured's umbrella policy specifies that its retained limits are the larger of either the minimum underlying comprehensive personal liability limits of $300,000 or $250. The insured's homeowner policy has a $300,000 limit of liability.

The insured is found legally responsible for covered damages of $500,000 when someone is injured. In this case, the primary coverage (the liability section of the homeowner policy) pays the first $300,000 (the retained limit) and the umbrella policy pays the remaining $200,000. There is no corridor or gap between the primary and excess coverage, and the insured pays no deductible himself.

Now, assume that the insured is found legally responsible for slander in the amount of $500,000. Coverage for personal injury damages is not provided under the homeowner policy.

However, coverage is provided under the personal umbrella, up to its policy limits of $1 million. In this case, there is no underlying coverage so the insured must pay the first $250 (retained limit) before the umbrella insurer is obligated to pay the remaining balance of $499.750.

Now, assume that the insured in these examples allows the required homeowner policy to lapse and is subsequently found legally responsible for covered damages of $500,000 when someone is injured on his property. In this case, there is no primary liability coverage available; however, the personal umbrella insurer is NOT relieved of its obligation to pay even though the insured has failed to maintain the basic liability limits required as a condition of obtaining and maintaining personal umbrella liability coverage.

Before the insurer pays, however, the insured, in essence, must take the place of the primary insurer and pay the amount that the primary insurer would have paid if the homeowner coverage had been in force. The umbrella insurer then responds in the same way it would have had the primary liability insurance been in force to act as the retained limit.

In this case, the insured pays the first $300,000 (the retained limit before the personal umbrella insurer pays the remaining $200,000. The insured does NOT pay an additional $250 deductible.

EXCESS VS PERSONAL UMBRELLA LIABILITY INSURANCE

Many insurance producers use the term *excess personal liability insurance* and *umbrella insurance* interchangeably. These two insurance coverages are actually quite different and should not be confused. Unlike excess liability that provides additional coverage only if the underlying policy provides coverage for a loss exposure, a typical personal umbrella policy will respond in two ways;

If the listed underlying insurance coverage, such as the homeowner policy or personal auto policy, are exhausted in the payment of a loss, the umbrella picks up the protection and continues payment on behalf of the insured until the personal umbrella's limit of liability is also exhausted.

If a loss occurs that is not insured under the underlying policies, because of policy exclusion or for any other reason, the personal umbrella policy will often cover a loss subject to a deductible, retained limit or self-insured retention payable by the insured. However, the umbrella policy does not cover every loss, and it should be analyzed to determine any coverage exclusions.

Required Underlying Limits

The insurer will include policy language that clearly states the types and minimum limits of liability that the insured must carry. In some policies, this provision is called maintenance of insurance of required underlying limits. A typical provision might read:

The named insured agrees that as of the inception and for the duration of this policy (1) the following underlying insurance shall be maintained in force for at least the minimum primary limits stated hereafter, and (2) that such underlying insurance insures all residences occupied by the insured and all farms, watercraft and land motor vehicles owned, rented, hired, or controlled by the named insured.

An umbrella insurer does not intend to provide first-dollar coverage; therefore, the insurer requires that certain primary insurance be in place to provide the first layer of liability coverage if a loss occurs.

Example:

To illustrate how a claim involving and umbrella policy should be settled, assume the umbrella insurer requires underlying automobile liability insurance with split limits of 250/500/50 (or a combined single limit of $500,000) and homeowner liability coverage in the amount of $300,000 before it will insure a personal umbrella policy for $2 million.

The insured purchases the required policies in the required amounts and an umbrella policy is issued. The insured is involved in an auto accident and found legally liable for the other driver's bodily injuries. Damages of $1.3 million are awarded. The insured's auto policy pays up to $500,000 for the covered accident and the umbrella policy pays the remaining $800,000.

To guarantee that the applicant is aware of its underlying insurance requirements, insurers include questions about underlying limits on their umbrella applications. In addition, when the umbrella policy is issued, the Declarations page typically includes information about the insured's primary insurance coverage.

The types of loss exposures, names(s) of the insurance carrier(s), policy numbers, and effective dates of coverage and limits of liability are shown. Finally, the policy will include some explanation of how a loss will be handled when the primary insurance required by the umbrella policy is in place.

Failure to Provide Underlying Limits

Although the insured is expected to supply certain underlying limits, these basic policies may be unavailable at the time of a loss for a number of reasons. For example, the insured may have allowed the primary policy to lapse or it may have been canceled for nonpayment of premium. The limits of coverage may be less than required by the umbrella insurer or may have been reduced by payments of losses. The primary insurance company may have become insolvent or it may refuse to pay a claim because a covered person has not complied with the terms of the primary policy.

Umbrella insurers intend to pay only for damages that exceed a retained limit. Therefore, insurers safeguard themselves by having certain coverage exclusions, which will apply if the underlying insurance is missing. For example, a policy might state:

If your "primary insurance" has terminated, is un-collectible, or reduced, this will not void coverage. In these cases, we will pay the same manner as though your "primary insurance" were in force, collectable and with required limits, and you had fully complied with all conditions or agreements.

This provision explains the insurer's intention to provide defense, investigation, legal fees, court costs or any similar fees or costs. However, the insured becomes personally responsible for the amounts of coverage that would have been in effect if the policies had remained in force. For example, if the underlying insurance would have provided the first $300,000 of liability coverage, the insured must pay that amount before the umbrella insurer steps in.

The insurer has no legal obligation until the retained limit has been met. It should be noted, however, that the umbrella insurer retains the right to enter the matter sooner and provide a defense. This could occur when the insurer sees the opportunity to quickly settle a lawsuit that could escalate if left uninvestigated or undefended.

Summary

The Insuring Agreements contain the promises the insurer makes to the insured. Some umbrella policies have relatively simple Insuring Agreements. While others include a number of definitions, exclusions, and conditions within their Insuring Agreements. Regardless of the policy wording, however, the Insuring Agreements provide a general description of the circumstances under which the policy becomes applicable.

In addition to Insuring Agreements, umbrella policies contain a separate section called conditions, which enumerates the duties of the parties to the contract, and in some cases, defines the terms being used. Many conditions found in an umbrella policy, such as notice of occurrence, assignment, and the cooperation of the insured, are common to most property-casualty policies. Other conditions, such as maintenance of underlying insurance and appeals, are peculiar to umbrella policies.

CHAPTER 7: RESTRICTIONS AND EXCLUSIONS

COMMON EXCLUSIONS

The personal umbrella policy provides broader coverage than any underlying liability policy, but it is not intended to cover every risk that a person might face. Like other property and liability policies, the personal umbrella includes a number of provisions to clarify that certain perils are not to be covered. The wording of various provisions determines what is specifically excluded under the policy.

Basically, policy exclusions are intended to prevent the insured from profiting from non-fortuitous losses, duplicate insurance coverage or unusual risks. To this end, a basic personal umbrella policy includes a number of exclusions that modify the policy's Insuring Agreements.

Understanding Policy Restrictions

Insurance policies contain a number of policy limitations or restrictions on specific perils, property, locations, or losses for which the insurance company does not intend to provide coverage. The personal umbrella liability policy is no exception. Policy exclusions are usually listed and explained in a separate section of the policy called "What Is Not Covered or Exclusions".

An Exclusions section explains any exceptions to the policy's Insuring Agreements and clarifies the insurer's intentions by limiting or modifying certain aspects of coverage that the insurer plans to provide.

In theory, the policy language should clearly express an insurer's intentions as they might apply to a wide variety of loss situations. Unfortunately, the meaning of certain phrases may be debated and it is not uncommon for the courts to find that coverage applies to losses that the insurer never intended to cover when the policy was developed.

In an attempt to be certain that an umbrella policy provides or limits certain coverage, an underwriter may issue an endorsement to amend, enlarge or completely eliminate coverage in the basic contract.

It should be clear that in order to determine what coverage a personal umbrella policy provides, one must study the entire policy including any endorsements and exclusions. In addition to those exclusions clearly outlined in the Exclusions section of the policy, other coverage limitations or exclusions may appear elsewhere in the policy. Coverage restrictions may even begin with the Insuring Agreements that state:

We will pay that portion of the damages for personal injury or property damage a covered person is legally responsible for which exceeds the retained limit.

This restrictive policy wording means that before the insurance company will make any payment for a claim under the personal umbrella, certain elements must be in place:

The insurance company will pay only its share of covered losses after certain other conditions are met.

A covered person as defined in the policy (usually the named insured, a family member or a person using an auto, recreational vehicle or watercraft owned by the insured with the insured's permission) must have been involved in the event.

The covered person must have done something (or failed to do something) that resulted: (1) in personal injury, usually defined as bodily injury, sickness, disease, death, disability, false arrest, libel, slander and so on; or (2) in property damage, usually defined as physical injury to tangible property, to another person.

The covered person must be held legally responsible or liable under law, as interpreted by the courts, for the action.

The insured must meet a retained limit, usually the larger of the total applicable limits of all required underlying insurance or some set amount, such as $250 or more, before the umbrella policy responds to the claim.

Reasons for Exclusions

An insurance company is not required to explain its rationale for incorporating various exclusions in its policy; however, exclusions are generally used to clarify what the insurer does not intend to cover. Depending on the insurance company's underwriting philosophy, provisions that eliminate coverage for specific loss exposures are included in personal umbrella policies for at least five reasons:

Exclusions help the insurer avoid financial catastrophe

The theory of insurance is that in paying the relatively small premium, each policyholder has benefited by exchanging the uncertainty of a large future loss for the certainty of a small immediate loss (the premium paid). Pooling of losses is the essence of insurance. However, risks must fulfill certain requirements before they can be insured. For example, the chance of loss must be calculable, which means the loss must be determinable and measurable. In addition, the loss should not be catastrophic, so insurers exclude coverage for losses, such as from war or nuclear radiation that involve an incalculable catastrophic potential.

Exclusions limit coverage of non-fortuitous (non-accidental) events

The policy does not intend to provide coverage for occurrences caused by moral or moral hazards.

Moral hazards are intentional acts directly attributable to the insured and caused by defects or weaknesses in human character; morale hazards include the mental attitude that may indicate a subconscious desire for a loss. The policy specifically excludes non-accidental losses that may result from these hazards.

For example, if the insured intentionally runs over a pedestrian, coverage would not be provided under either the personal auto policy or the personal umbrella policy.

Insurance coverage is provided only for losses that are accidental and unintentional for two reasons. First, if intentional losses were paid, moral hazard would be increased and premiums would rise as a result. A rise in premiums could result in fewer people purchasing insurance, thereby making prediction of future losses difficult. Second, covering intentional bodily injury or property damage is contrary to the public good.

Exclusions help to standardize the risk

If an insurance company were to assume every possible risk facing a policyholder, the insurer would soon be out of business. To prevent adverse selection, an insurance company tries to cover only those risks that meet certain company underwriting guidelines.

It would be inequitable to require all insureds to share the costs of covering the significant loss exposures of a few risks. Therefore, any loss exposures that would require special rating, underwriting, or loss control, such as aircraft liability coverage or professional liability coverage, are usually excluded from the umbrella policy. In addition, coverage that is not needed by the typical purchaser of a personal umbrella policy is excluded.

This coverage includes workers' compensation and care, custody, or control coverage. People who need this coverage may usually purchase them separately for an additional premium.

Duplication of coverage is usually prevented

Insurance is a contract in which the insurer, in consideration of the payment of a premium by the insured, agrees to make good the losses suffered through the occurrence of a designated, unfavorable eventuality.

Because property and liability insurance policies are essentially contracts of indemnity, the insured cannot be enriched by a loss and may only receive reimbursement for the actual damage sustained. Therefore, as discussed in previous chapters, umbrella policies are designed to dovetail with the underlying insurance policies and to pick up where the underlying policy leaves off. When the insured receives reimbursement for part or all of the loss from any other source, he or she cannot receive duplicate payment from the umbrella insurer.

If two or more personal umbrella policies apply to a loss, each policy pays its share of the loss on a pro rata basis.

Premiums are kept at a reasonable level

One of the most important functions of an insurance company relates to the pricing of its policies. The insurer does not know in advance what its actual costs are going to be for the year but it relies on the company's past loss experience and industry statistics to determine its rates. Insurance pricing must meet certain regulatory and business objectives in order to keep premiums at a reasonable level.

From a regulatory standpoint, an insurer's rates must be adequate (high enough to pay all losses and expenses while earning a profit for the company), not excessive (rates should not be so high that policyholders are paying more than the value of their insurance coverage) and not unfairly discriminatory (similar exposure units should be charged the same rates).

From a business standpoint, an insurance company's rating system should be:

- Easy to understand;
- Stable over short periods so consumer satisfaction can be maintained;
- Responsive over time to changing loss exposures and economic condition;
- Encouraging of loss prevention activities by rewarding insureds with reduced rates for loss control measures that reduce the frequency and severity of losses.

Common Personal Umbrella Exclusions

A liability insurance policy promises to pay on behalf of the insured the amount (up to the policy limit) that the insured becomes obligated to pay because of the liability imposed on him by law for damages caused by a covered occurrence. As explained previously, the term occurrence is defined as an accident that results in bodily injury or property damage neither expected nor intended by the insured. This definition includes continuous or repeated exposures to conditions that result in injury or damage.

Personal umbrella liability protection is quite broad, but it is possible for the insurance agent and the insured to overestimate the extent of financial protection actually afforded by a policy if they do not fully understand what is excluded from coverage.

Every peril or hazard is not covered. If, for example, a claim arises and the details of the incident show that the source of the claim is an excluded condition or incident, no coverage is afforded under the umbrella policy.

The insured would be personally responsible for the expense of investigating and defending the claim. Furthermore, if the insured and the insurance company differ as to the details of the incident, it is the responsibility of the insured to convince the insurer that the incident falls within the policy coverage and should be covered.

Although personal umbrella policy exclusions will vary by insurer, most companies will usually exclude coverage for loss exposures that are better insured under another policy.

Workers' Compensation

Most personal umbrella policies exclude coverage for injuries to employees that should be covered by a workers' compensation policy. Workers' compensation insurance covers loss of income, medical and rehabilitation expenses that result from work-related accidents and occupational diseases.

This insurance evolved as a means of enabling employers to meet the requirements of the workers' compensation laws of the states in which they operate. Prior to the enactment of these laws, the only recourse open to any employee injured on the job was a negligence lawsuit against the employer - a process that put the employer and the employee on opposite sides of a legal argument.

Workers' compensation legislation protects workers by providing benefits to a worker or a worker's dependents for injury, disability or disease contracted by the worker in the course of his employment.

Compensation is made without regard to fault or legal liability. Although specific workers' compensation benefits vary by state, medical and hospital expenses are generally fully reimbursed and monetary allowances are granted for various types of disability. In addition, burial expenses are paid up to a statutory limit.

Care, Custody or Control

Standard liability policies, including most personal umbrella policies, contain a Care, Custody or Control Exclusion. This provision eliminates coverage for property belonging to others that for some reason is in the insured's possession and the insured has agreed to assume liability for damage to the property.

The intention of this exclusion is to eliminate coverage for damage to property that: (1) should have been prevented by the insured by exercising care; or (2) should have been covered by some other form of insurance coverage. Unfortunately, courts do not always agree about what constitutes "care, custody or control." The courts may determine, for example, that leased machinery and equipment or property under construction is considered to be under the insured's custody. Therefore, the insured is held responsible for losses to that property.

Some umbrellas provide coverage if the insured was not obligated to provide insurance coverage property in his care, custody or control was damaged. In addition, umbrella coverage usually applies on an excess basis if the primary policy covers the loss.

Nuclear Energy

The personal umbrella policy is not intended to cover the catastrophic risk of a nuclear disaster. In addition, loss caused by nuclear reaction or radioactive contamination, whether controlled or uncontrolled, is excluded from the underlying property and casualty policies.

There are specific policies to cover nuclear risk under various pooling arrangements. Nuclear Energy Liability policies, issued by nuclear insurance pools, cover firms that own or operate nuclear reactors and provide proof of a company's financial responsibility if a nuclear accident should occur.

Policies are issued by any of the following or their successors:

- American Nuclear Insurers;
- Mutual Atomic Energy Liability Underwriters;
- Nuclear Insurance Association of Canada.

These insurers issue policies that cover virtually everyone against liability for causing a nuclear incident. Therefore, liability coverage will not be duplicated under the personal umbrella policy.

War Risks

Insurance companies only cover risks that they consider to be insurable. Generally, personal umbrella policies have specific wording to eliminate liability coverage for large loss exposures that are considered uninsurable by most insurers. For example, personal umbrella policies usually contain War Risk Exclusion for losses from war, civil war, insurrection, rebellion, or revolution.

The insurer is not liable for loss by fire or other perils caused, directly or indirectly, by enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack. Likewise, damage caused by internal rebellion or other warlike acts is excluded.

Intentional Acts

Any intentional acts of the insured that can be directly attributed to the insured are considered moral hazards and are excluded under most liability contracts. However, in most cases, coverage is provided for unintentional torts caused by the insured's negligence or for the acts of others for which the insured is vicariously liable.

For example, if the insured's friend borrows a covered auto and intentionally runs over a mutual acquaintance, the insured would be vicariously liable if the driver were acting as an agent of the insured at the time of the injury. In essence, the driver while driving the insured vehicle with the permission of the insured is also an insured. However, in this situation, if the insured were driving and the injury was caused by the intentional act of the insured, coverage would be excluded.

Aircraft

Many policies define the term aircraft as a plane, seaplane, amphibian, or helicopter, including operating and navigational instruments; radio equipment and other equipment attached to or carried on the aircraft.

Aircraft may also be defined as a heavier-than-air or lighter-than-air vehicle designed to transport persons or property through the air. The definition usually excludes coverage for a hovercraft, which is considered to be a recreational vehicle.

Aircraft liability insurance is similar in design to an automobile liability policy and provides coverage for losses arising out of the ownership, maintenance, or use of aircraft for which the insured is liable. Under this coverage, two types of bodily injury may be covered: Bodily Injury Liability, excluding passengers, and Passenger Bodily Injury Liability.

Typically, Property Damage and Medical Payments are also covered.

Although some personal umbrella policies provide aircraft liability coverage, most exclude coverage for any personal injury or property damage due to the ownership, maintenance, use, loading or unloading of aircraft owned or chartered by the insured.

However, if the insured has an underlying aircraft liability policy and it is listed on the personal umbrella Declarations page, some coverage may be provided by the umbrella. In most cases, the insurer will pay the difference between what is payable under the aircraft liability policy and the total legal liability of the insured, up to the liability limit of the umbrella.

Watercraft

Many liability policies, including the Commercial General Liability policy, contain an exclusion for "bodily injury" or "property damage" that arises from the ownership, maintenance, operation, use, loading or unloading of any owned or non-owned watercraft. The personal umbrella liability policy will also typically exclude this coverage.

There is an exception, however, in that this exclusion does not apply to any injury or damage arising from owned or non-owned watercraft while they are ashore and on premises owned, rented, or controlled by the insured.

It should be noted that the homeowner policy provides some liability coverage for certain types of watercraft owned or operated by the insured. For example, liability coverage is provided for non-owned watercrafts that are not sailing vessels and are powered by an inboard or inboard-outboard engine or motor power of 50 horsepower or less. When there is underlying coverage, most umbrellas provide excess coverage in the same way that the primary policy covers the insured.

For example, if the primary policy covers "property damage" due to the ownership, maintenance, use, loading or unloading of any watercraft under 25 feet in overall length, the umbrella policy will normally pick up the excess liability coverage.

Recreational Vehicles

For insurance purposes, the definition of a recreational vehicle includes vehicles such as snowmobiles, mini bikes, all-terrain vehicles (TVs) and any similar vehicles designed principally for use off public roads, whether or not the vehicles are subject to motor vehicle registration. The definition does not include motorcycles.

Some personal umbrella policies exclude liability arising out of the ownership, maintenance, or use of recreational vehicles unless the insured carries underlying limits of liability for these vehicles. For example, an insured may add snowmobile liability coverage for $100,000 to a homeowner policy by endorsement.

If the insured also purchases a personal umbrella policy, that policy typically provides excess liability protection for the insured as long as the underlying limits remain in force.

Business Pursuits

Many umbrella policies exclude coverage for liability arising out of a business activity or business property unless the liability results from the named insured's or a family member's use of a private passenger vehicle.

The insurer's intention is to limit coverage for any trade, profession, or occupation in which the insured is engaged and which might increase the chance of loss. The definition of business pursuits usually applies to any type of usual or ongoing business, ranging from a professional office in the home to weekly garage sales.

In many cases, the umbrella insurer will provide coverage for incidental business pursuits if this loss exposure is covered by an underlying insurance policy, but coverage will be no broader than the underlying insurance coverage.

PROFESSIONAL LIABILITY INSURANCE

Personal umbrella policies contain exclusions for all claims arising out of a professional person's errors or mistakes made in the performance of the duties of that profession. When a professional fails to meet the standards of skill and care generally accepted for that profession or occupation and causes injury or damage to a client, however, that professional may be held liable and may be required to pay money damages to the injured party.

There are two types of professional liability insurance that have been developed to cover this type of legal liability. One is malpractice insurance where the negligent act causes direct injury or harm to a human being. The other is errors and omissions insurance where the negligent act causes losses involving physical things, which in turn may cause damage or injury to both people and property.

Directors and Officers Liability

The personal umbrella policy typically excludes coverage for liability due to the insured's activity as a member of a board of directors or as an officer of an organization other than a charitable, religious, or civic nonprofit organization. This exclusion is in keeping with the personal umbrella policy's intention not to provide coverage for business activities that may be covered by another type of policy.

For example, Directors and Officers Liability Insurance (D & O Insurance) has been developed to cover the director or officer for liability claims resulting from poor judgment and wrongful acts. D & O Insurance pays on behalf of directors and officers (or reimburses their corporation if the executive receives indemnification) for claims arising out of error, neglect, and breach of duty or misleading statement.

The policy also provides for legal defense. It will not cover any active or deliberate fraud. Although the personal umbrella policy excludes liability for business activities, it typically covers liability due to the insured's civic activities. For example, assume that a teacher for defamation of character sues the insured and other members of a school board collectively and individually.

Most personal umbrella policies would determine that service on a school board is not a "business activity" and would, therefore, provide a legal defense for the personal actions of the insured. (It is also possible that the school board could provide defense for individuals in such a matter and that any judgment would be paid by the board.) In addition, the personal umbrella usually provides legal defense when an insured is allegedly slandered or slanders someone else.

For example, assume the insured runs for a public office and, during the course of the campaign, he or she accuses an opponent of corruption in several newspaper ads and radio spots. If the insured is later sued for libel or slander, the cost of the legal defense and any judgment against the insured will usually be paid by the personal umbrella carrier.

CHAPTER 8: THE UNDERWRITING PROCESS

EVALUATING LOSS EXPOSURE

As part of their duties, underwriters identify and evaluate loss exposures, price the insurance product, determine policy terms and conditions make the final risk selection and monitor and service the account. The series of steps that underwriters use to select evaluate and approve (or reject) applicants for insurance is called the underwriting process. An underwriter who understands and observes each step in this process is likely to achieve a profitable book of business for the insurer.

Identifying and selecting a Risk

The personal umbrella underwriting process begins with the identification and selection of a particular risk. In most cases, it is the property-casualty insurance producer who initially determines whether a risk will be acceptable to the company. In essence, the producer is a field underwriter for the company who often selects the umbrella risk from his existing book of business. The producer typically has had personal or business dealings with the applicant and may attest to his personal reputation, background, and loss experience over a long period.

In fact, the insured's long-term relationship with the insurance producer is often the primary reason that a personal umbrella policy is issued. In many cases, the prospect for umbrella coverage will be an affluent client, although this is not a requirement for umbrella coverage. As we have stated, anyone who has loss exposures that could result in large liability claims is a candidate for personal umbrella coverage.

However, the producer should be careful not to select applicants who present loss exposures greater than those assumed by the insurer in its rates or premiums. Risks should be in the good to above-average range to ensure that they may be profitably underwritten.

Analyzing Underwriting Information

The insured is usually asked to answer a series of questions on a detailed application for insurance. Although the producer may complete the application, the named insured is usually asked to verify the information and then sign the application. The application requests information about the risk being considered for insurance coverage, and in some cases, the completed application will be attached to and become part of the umbrella policy.

The questions on the application will vary by insurer, but most applications will ask for information in three specific categories:

- Personal information about the named insured and other members of the household;
- Information about real and personal property owned, leased, or used by the insured that might present a liability exposure;
- General insurance information that can be used to assist the underwriter in determining a premium to be charged for the umbrella coverage.

After the application has been completed and signed by the applicant, the insurance producer forwards the information to the line underwriter (usually located in the home office) who makes the final determination about whether the risk can be written and at what premium.

The home office underwriter analyzes the information provided on the application and measures it against a theoretically ideal risk to judge whether the applicant is a good candidate for insurance.

Personal Information

The underwriter needs personal information about the insurance applicant to determine whether the risk presents any unwanted hazards for the company. The underwriter looks for specific warning signs of potential moral or morale hazard.

For example, assume that during the ten years the insured has carried homeowner and auto insurance with a particular insurer he or she has maintained extremely low limits of liability. The applicant's sudden interest in increasing the underlying limits and obtaining an umbrella may indicate that this is a poor umbrella risk.

The underwriter should question what has happened to make the applicant now interested in increased limits. The application provides the underwriter with basic information about the individual applying for insurance (the named insured) and members of the named insured's household. The information is used to give the underwriter a feeling for the loss exposures faced by the entire household. The application typically asks for the following details:

- Name, mailing address and residence address of the applicant;
- Marital status; age (or birth date) of the applicant and spouse, in states where such questions are permitted;
- Occupation and employer of applicant and spouse (if any);
- Information about stability factors, such as ownership of home, years at present address, previous residence address and length of time at that address; and
- Information about any liability claims made against the insured during a specified period (usually three to five years).

Such information is intended to assist the underwriter in deciding whether the applicant has any unusual exposures to loss. For example, many insurers will decline coverage for people, such as actors, professional athletes and politicians, whose professions or activities expose them to extraordinary publicity and potentially large lawsuits.

Property Loss Exposure

The personal umbrella liability application asks the applicant to describe any residence or other real property owned by the insured that could generate a liability claim. The underwriter is specifically looking for clues about the property, such as inferior construction or poor housekeeping that might increase the chance of loss.

Because the personal umbrella typically provides coverage on a worldwide basis, the underwriter needs information about all the property at risk. The application seeks:

- Information about all residences occupied by the applicant, type of interest (owned or rented), description of any other buildings on the residence premises, the number of swimming pools at each location;
- Information about any farms owned or rented by the applicant, including the acreage and value of any leased property;
- Information about all automobiles owned or leased by the applicant, including the type and principal operator of each, where it is garaged and the rate class used for each vehicle;
- Information about watercraft owned or leased by the applicant, including manufacturer, model year, type, length, horsepower, location of operation and whether any underlying policy has restrictions on water-skiing;
- Information about any aircraft owned or used by the applicant with descriptions of each aircraft and additional information about the pilot;
- A description of employer's liability or workers' compensation exposures, including number and type of domestic and/or farm employees;
- A description of all business pursuits and business properties of the applicant;
- A description of any unusual hazards, such as dangerous animals on the premises, water-skiing activities by any member of the family, child care duties (such as baby-sitting) by any member of the family, plans to enter a race, contest, or exhibition, etc.

GENERAL INSURANCE INFORMATION

An underwriter needs as much general information about the risk as possible to properly quote the risk. Rating is based in part on an underwriter's experience and judgment and without fairly complete knowledge of the risk; an underwriter cannot provide a competitive quotation. At the very least, an underwriter will request the following:

- The policy limits desired and the requested effective date;
- A schedule of all applicable underlying policies: automobile, homeowner, boat, recreational vehicles, aircraft, employer's liability, or workers' compensation insurance (information typically includes the name of the insurer, policy number, effective dates, limits of liability and the premium per policy);
- Information about other insurance policies in force, such as those providing coverage for business pursuits or business properties (any exclusions or limitations of liability coverage must be noted on the application for the personal umbrella policy);
- Information about any previous personal umbrella insurer, including name of the insurer, policy number, effective dates, and reason for changing insurers; and
- An explanation of the circumstances if any insurer has ever canceled refused or denied renewal of a personal umbrella policy for the applicant.

ACCEPTING OR REJECTING THE RISK

Based on the personal, property and general information received on the application and an analysis of that information, the underwriter will make a decision about whether to accept or reject the risk. Many underwriters will not go to great lengths to secure information other than that on an application.

They assume that if another insurer willingly provided underlying insurance, the risk should be acceptable for umbrella insurance. However, some insurance companies will write umbrella coverage only if they also write the required underlying coverage. Other insurers write stand-alone policies and do not require that they issue the underlying policies but only that the coverage's are in place with some insurance company.

The underwriter determines the acceptability of a particular risk by checking it against a large number of factors known to be related to loss potential. Some underwriters feel that if a property is eligible for a homeowner policy under another insurer's underwriting guidelines, it is also eligible for umbrella coverage. Most underwriters would agree, however, that even though a risk is eligible for insurance coverage, it might be declined for any number of reasons. For example, the applicant may have an attractive nuisance, such as a swimming pool or a vicious dog, which is not properly safeguarded.

Although the primary insurer may consider this an acceptable risk, the umbrella underwriter may be concerned about the likelihood of a multimillion-dollar lawsuit if a child drowns in the insured's pool or is killed by the insured's dog. It is likely that an umbrella underwriter would decline such a risk or require additional safeguards before the umbrella policy is issued. The underwriter may also charge an additional premium for certain hazardous exposures.

Most insurers refuse to issue coverage for persons who are engaged in illegal activities, who have unusual exposures to libel or slander suits, such as broadcasters and newspaper reporters, or whose activities cause them to face significant publicity, such as actors, professional athletes, public lecturers, and politicians. The general feeling among insurers is that such persons offer substantial exposure to lawsuits and large liability settlements.

Pricing the Risk

One of the most important parts of a personal lines underwriter's job is to determine the proper pricing for various insurance products. The policy premium is determined by multiplying an insurance rate, the dollar amount charged per a particular amount of insurance coverage, by the amount of insurance needed.

Actuaries who collect data and analyze the many factors that determine the relative hazards of different risks usually accomplish the highly technical procedure of establishing rates. The costs of establishing rates would be prohibitive if each insurance company were to maintain its own rating bureaus. A practical method of solving this problem is for groups of insurers to act together to set up a central body to promulgate proper rates. In addition, the pooling of various insurers' experience makes more accurate results possible.

Strictly speaking, no two personal umbrella risks present exactly the same hazards. Even if two applicants have identical dwellings, the structures will differ as to their contents, maintenance, and number of occupants and so forth. The applicants will have different types and numbers of automobiles, insurance requirements, loss histories, etc. Because these applicants have different loss exposures, an underwriter will use specific (or schedule) premium rates. The rate is determined by an analysis of the insured's application, which is compared in terms of the relative loss exposures against a theoretical average risk. Using a predetermined average price as a base, the risk being considered is given credit for superior elements, such as fire-resistive construction, loss control devices and high-level maintenance.

Risks with hazardous exposures, such as swimming pools, are often surcharged if the underwriter wishes to cover those types of risk.

Issuing the Policy

After the underwriter has analyzed and priced the risk, he will forward a written premium quotation to the producer. The underwriter will note the general terms of the policy, such as the required underlying limits of liability, the amount of the self-insured retention, the proposed effective date of the policy and so forth.

The producer then forwards the information to the insured who accepts or declines the quote. If the insured accepts, the underwriter proceeds with the issuance of the actual policy. In almost all cases, the producer cannot bind or issue personal umbrella liability coverage.

Although the basic coverage do not vary greatly, the policy appearance and format will be quite different. In addition, the underwriter may change the coverage and modify the basic policy by endorsement. The underwriter may wish to amend the general policy provisions to comply with the special needs of the applicant, to cover unique situations also covered by the underlying policies or to restrict certain risks that the underwriter does not wish to cover.

Monitoring the Risk

The final step of the underwriting process is monitoring the risk throughout the policy term to confirm that the decision to write the risk was a good one. The underwriter often works with other departments, such as the accounting and claims departments, to be certain that the premiums are paid in a timely manner and that the insured's loss experience is not excessive.

As part of the monitoring step, the underwriter will often follow up with the producer about three months before the umbrella's expiration date to offer a renewal policy. Although most umbrella policies are annual policies without a guaranteed renewal provision, some underwriters will send a notice of non-renewal if the company does not want to reissue the coverage.

Sending a notice of non-renewal informs the producer and the insured that umbrella coverage will have to be placed with another insurer and also protects the insurer if there is some dispute about whether coverage should have been in force after a specific date. In some states, this notice may be required by statute.

CHAPTER 9: COMMERCIAL UMBRELLA POLICY

As in regular umbrella coverage commercial umbrella policies provide high limits of insurance over and above primary policies.

Because risk and loss exposure vary greatly, there are no standard forms of Commercial Liability Insurance and most companies use their own loss statistics in underwriting such policies.

The insurance company will require full information about the business operations, the primary liability insurance portfolio, and previous loss experience over a specified period of years to properly make a judgment in issuing an umbrella policy.

Underlying insurance is an important factor and the Commercial general Liability policy, the Commercial Auto policy, and Employer's Auto Policy play important roles in determining acceptability and risk cost. A high general aggregate limit is a particularly important factor.

The Commercial Umbrella Liability policy provides broader coverage than the primary policy replaces primary policy limits and extends the primary loss limits. A Commercial Umbrella policy can insure individuals, organizations, a partnership, joint ventures, owners, executive officers, and directors, stockholders, and employees.

In the case of individuals, officers, directors, stockholders and employees, coverage is restricted with respect to their duties to the company. In the case of motor vehicles such as cars, trucks, trailers, etc., umbrella policies usually provide coverage for individuals, other than the name insured, who drive a motor vehicle that the name insured owns, hires, or borrows. The exception to this is usually anyone who is employed and performs duties for an auto sales agency, repair shop, service station, storage garage or public parking place that the named insured does not operate.

Commercial Umbrella Liability offers two forms of coverage: Coverage A- Bodily Injury and Property Damage Liability and Coverage B-Personal and Advertising Injury Liability.

The policy usually defines "advertising Injury" as:

- Oral or written publication of material that slanders or libels a person or organization;
- Disparagement-misleading or untrue statements about a person's organization's goods, products, or services;
- Oral or written publication of material that violates a person's right of privacy;
- Misappropriation of advertising ideas or style of doing business;
- Infringement of copyright, title, or slogan.

Commercial Umbrella Liability policies can be either occurrence or claims made contracts.

Common exclusions in underlying commercial liability policies that are normally covered under a commercial umbrella liability policy are:

- Contractual liability;
- Liquor liability;
- Employment in violation of the law;
- Transportation of Mobil equipment.

COMMON COMMERCIAL UMBRELLA EXCLUSIONS

- Advertising injury arising out of breach of contract;
- Employer, employee discrimination;
- Restrictions to real property and work in progress damage;
- Faulty workmanship;
- Property damage to the insured's products;
- Damage to the insured's work;
- Impaired tangible property;
- Product recall liability.

POLICY CONDITIONS

Books and Records - the insurance company reserves the right to examine the insured's books and record at any time during the policy period and up to three years thereafter, or one year after a final settlement.

Inspections and Surveys at any time at the insurance company's discretion.

Premium Audit - the insured must keep records of information needed by the company for premium computation, and sent to the company upon request.

Arbitration Clause - in some cases a voluntary agreement between the insured and the insurer, but in some states mandated by law prior to court action.

CHAPTER 10: SMALL BUSINESS LIABILITY INSURANCE

Coverage for certified public accountants

Any provider of professional services needs professional liability coverage, and accountants are typical of this category.

An accountant's policy should include "prior acts," which are claims made for alleged malpractice that occurred before the policy was purchased.

It is important for the insured that the policy include "long tail" coverage, meaning that if the policy is discontinued, there will be a window of time (such as one year, three years, or even unlimited) during which claims made against the firm for actions while the policy was in-force are still covered.

It is important to make sure that the insured has insurance coverage for every facet of their firm's work, which could include general accounting services, personal financial planning, audits, tax preparation, and consulting services.

Also, an accountant should have coverage that will pay their fees for attorneys, court costs, and other expenses related to state licensing board investigations or professional liability inquiries.

Bundled Coverage

Business owners' policy (BOP) is a combination or "package" policy for small- to medium-sized businesses that covers both business property and liability for bodily injury or property damages. Commercial general liability insurance (CGL) is coverage that provides for liability arising from fire, product advertising, and personal liability, and for medical payments.

These types of policies have a policy limit is in place, so the insurance company will not pay any claims once the total number of claims from all liabilities reaches their limit.

Accounts Receivable Coverage

If a fire or another disaster destroys records against which the individual is insured, they will have a hard time collecting money owed to them. This coverage reimburses those sums, plus the expense of reconstructing the records. (It doesn't insure the physical value of the records, such as computer disks.

Employee benefits coverage

Generally includes group health and pension/retirement plans; also can include group life insurance, disability income insurance, and/or accidental death and dismemberment.

Employee benefits liability

Protects employers against accusations of mismanagement or omissions in dealing with employee benefits plans. For instance, an employer could be sued for giving the wrong advice about a retirement fund or for neglecting to enroll an employee in group health.

Business personal property insurance

Covers all personal property that's on the business premises, but only while it's on the premises. There can be limited coverage for the same property while it's off-premises.

Computer coverage

For losses resulting from damage to the computer equipment or network.

As companies become more dependent on their computer networks for vital data, business continuity and communications, their vulnerability to cyber catastrophes increases.

The dynamics of risk management have changed with technology. To help companies mitigate their risk of potentially catastrophic losses, the insurance industry has developed cyber insurance products.

The insurance industry plays a pivotal role in securing cyberspace by creating risk-transfer mechanisms, working with the government to increase corporate awareness of cyber risks, and collaborating with leaders in the technology industry to promote best practices for network security.

Computer viruses caused an estimated $13 billion in damage in 2001, according to American International Group's e-Business Risk Solutions.

Premiums written for cyber insurance are likely to exceed $2 billion within the next four to five years as companies recognize existing gaps in their coverage.

Although cyber crime and accidental losses related to computer systems are taking a huge financial toll on businesses, corporate America has been slow to come to terms with this new reality. An Ernst & Young report, "Global Information Security Survey 2003," found that 90 percent of 1,400 organizations surveyed recognize that information security is of high importance and 78 percent identify risk reduction as the major influence on their information security spending.

In spite of this concern, over 34 percent of organizations say that their ability to determine if their systems are under attack is less than adequate and more than 33 percent acknowledge that they are inadequate in their ability to respond to incidents. Two-thirds say they are not compliant with applicable security regulations.

Cyber Crime

In May 2003, the Computer Security Institute (CSI) in San Francisco, an association of computer security professionals, released the results of its eighth annual Computer Crime and Security Survey. The survey was conducted by CSI with the participation of the San Francisco Federal Bureau of Investigation's Computer Intrusion Squad.

The report confirms that computer crime and other information security breaches remain a major threat. The survey found that overall financial losses from 530 survey respondents totaled $201,797,340, down significantly from 503 respondents reporting $455,848,000 last year. (75 percent of organizations acknowledged financial loss, though only 47 percent could quantify them.). Losses reported for financial fraud were significantly lower, at $9,171,400.

This compares to nearly $116 million reported in 2002. As in prior years, theft of proprietary information caused the greatest financial loss ($70,195,900 was lost, with the average reported loss being approximately $2.7 million). In a shift from previous years, the second-most expensive computer crime among survey respondents was denial of service, with a cost of $65,643,300 — up 250 percent from last year's losses of $18,370,500.

Survey results illustrate that computer crime threats to large corporations and government agencies come from both inside and outside their electronic perimeters, confirming the trend in previous years. Forty-five percent of respondents detected unauthorized access by insiders. But for the fourth year in a row, more respondents (78 percent) cited their Internet connection as a frequent point of attack than cited their internal systems as a frequent point of attack (36 percent).

One major hindrance to collecting valid information on cyber-crime has been the lack of reporting of incidents. In the CSI/FBI 2002 Computer Crime and Security Survey only 34 percent of companies that had experienced at least one computer intrusion reported the incident(s) to law enforcement. This may be changing. According to the Centers at Carnegie Mellon University's Software Engineering Institute, which focuses on ensuring the integrity and survivability of computer networks, the number of incidents reported rose by 377 percent between 2000 and 2002, increasing from 21,756 to 82,094.

An incident may involve one site or possibly thousands of sites. The CERT® Centers also indicate the number of potential system vulnerabilities has increased by 378 percent, increasing from 1,090 in 2000 to 4,129 in 2002.

Because of the nature of the problem and the potential for catastrophic losses, a major government-sponsored initiative to develop a strategy for dealing with cyber-crime was undertaken in 2002. In the second half of 2002 the White House's report, "The National Strategy To Secure Cyberspace" urged the President's Critical Infrastructure Protection Board to work with the insurance industry on ways to expand the availability and utilization of insurance for managing cyber risk.

An insurance section added to the report addresses the unique role that insurance can play in working with businesses and minimizing risks associated with cyber security challenges. It lists five recommendations that focus on insurance products designed to minimize and cover cyber losses.

Recommendations include encouraging the insurance sector to consider providing specialized cyber insurance products, that the government encourage the use of insurance as well as other risk management techniques, and that the private and public sectors collaborate on and fund research to develop the data and risk models necessary to quantify and control cyber loss exposures.

While computer crime has been the focus of most of the attention of the media and mitigation efforts of insurers and corporations, other risks associated with computer-related activities such as loss of data from power blackouts may be characterized as accidental.

A 2002 survey of 501 information technology (IT) managers and risk managers at 460 U.S. companies found that many underestimate the risks of electronic commerce and are not training employees to cope with them.

Few companies have assessed the third-party liability risk associated with storing customer data, including credit card and Social Security numbers. Only 55 percent of the risk manager respondents have reviewed existing coverage for electronic risk coverage. Fewer than half of those report they are covered for intellectual property infringement.

Even fewer are covered for hacker damage and customer privacy violations.

Larger companies are no better prepared than smaller companies. Only 24 percent of risk managers and 14 percent of IT managers rated their companies as "excellent" in managing cyber risk. About 25 percent of both groups rated their companies as "poor" or "fair." And 75 percent of both groups rated employee understanding of the risks as "poor" or "fair."

A recent survey conducted by the Human Resource Institute of Eckerd College confirmed the findings of the St. Paul survey that U.S. businesses were unprepared to deal with and/or unprotected from computer-related risks.

This survey found that of the 70 large companies that responded, only 31 percent have computer software and services errors and omissions coverage; 23.6 percent have business interruption coverage; 27.3 percent have patent infringement coverage; 21.8 percent have media liability coverage; 18.2 percent have coverage for crime loss; and 12.7 percent have coverage for unauthorized access or use.

In comparison, 52.7 percent carry traditional directors and officer's coverage and 41.8 percent have coverage for product liability. Twenty-one percent of respondents indicated that outside hackers have compromised their systems.

Perhaps most significantly, the Ernst & Young Global Information Security Survey found that only seven percent of organizations surveyed had a specific insurance policy to cover them from losses due to damages arising from information security breaches.

About a third incorrectly thought that these losses were covered by their general policies. About the same percentage knew they lacked coverage and almost one-quarter said they did not know the answer to the question.

The development of computer communications has brought about a whole new area of security considerations. These include types of attacks, such as viruses and hackers; sources of attacks, such as foreign governments, foreign corporations, individuals; and points of entry, such as e-mail.

Network Security Insurance, more widely known by names such as cyber insurance and hackers insurance, has been in existence only since the late 1990s. The major factor that led to the creation of the insurance was the development of the Internet as a commercial tool, with companies managing large amounts of data electronically, including customers' personal information, and seeing the need for some form of protection from accidental and criminal loss. These companies in turn began requiring their vendors to have some form of Network Security Insurance.

E-commerce risks are divided into two categories, technical and liability.

On the liability side it noted that every sort of tort is multiplied by use of the Internet, every contractual relationship takes on additional aspects, and the opportunity for crime is increased exponentially.

Cyberspace torts differ from their traditional predecessors by multiplying the number of intellectual property claims, raising complex, multi-jurisdictional issues that will drive up defense claims, and presenting arguments about whether or not these cyber torts constitute "advertising" within the meaning of the policy.

One of the first major cyber attacks that served as a wakeup call to the huge potential for damage that could be inflicted through computer systems was the Love Bug, a computer virus that carried the message "ILOVEYOU" and disabled computer networks around the world in 2000.

The Love Bug virus traveled around the world in a matter of hours, affecting 20 countries and 45 million users and causing companies an estimated $8.75 billion in lost productivity and remediation efforts.

Traditional insurance policies such as standard property and commercial general liability (CGL) insurance do not adequately deal with the risks of a cyber attack or network security failure.

While in the past there have been uncertainties as to which cyber risks are covered under traditional business policies, CGL policies now make it clear with specific exclusions they do not cover data and other network security risks.

Now, specialized cyber-risk coverage is available primarily as a stand-alone policy. Each policy is tailored to the specific needs of a company, including the technology being used and the level of risk involved. Both first- and third-party coverage are available, including:

Loss/Corruption of Data – covers damage to or destruction of valuable information assets as a result of viruses, malicious code, and Trojan horses (a general term referring to programs that appear desirable, but actually contain something harmful).

Business Interruption – covers loss of business income as a result of an attack on a company's network that limits the ability to conduct business, such as a denial-of-service computer attack. Coverage also includes extra expenses, forensic expenses, and dependent business interruption.

Liability – covers defense costs, settlements, judgments and, sometimes, punitive damages incurred by a company as a result of:

- Breach of privacy due to theft of data (such as credit cards, financial or health- related data);
- Transmission of a computer virus or other liabilities resulting from a computer attack, which causes financial loss to third parties;
- Failure of security, which causes network systems to be unavailable to third parties;
- Rendering of Internet Professional Services, and Allegations of copyright or trademark infringement, libel, slander, defamation, or other "media" activities in the company's web site.

Cyber Extortion – covers the "settlement" of an extortion threat against a company's network, as well as the cost of hiring a security firm to track down and negotiate with blackmailers.

Public Relations – covers those public relations costs associated with a cyber attack and restoring of public confidence.

Criminal Rewards – covers the cost of posting a criminal reward fund for information leading to the arrest and conviction of the cyber-criminal who attacked the company's computer systems.

Cyber Terrorism – covers those terrorist acts covered by the Terrorism Risk Insurance Act of 2002 and, in some cases, may be further extended to terrorist acts beyond those contemplated in the Act.

Identity Theft – provides access to an identity theft call center in the event of stolen customer or employee personal information.

Depending on the policy, coverage can apply to both internally and externally launched attacks as well as to viruses that are specifically targeted against the insured or widely distributed across the Internet.

Premiums can range from a few thousand dollars for base coverage for small businesses (less than $10 million in revenue) to several hundred thousand dollars for major corporations desiring comprehensive coverage.

Crime insurance covers employee dishonesty, forgery, alteration, and other fraud, as well as losses from theft and burglary.

Errors & omissions liability coverage – Protection against claims alleging that negligence or omissions on the part of the employer-led to personal injury or property damage.

Employment practices liability insurance (EPLI) – Coverage for lawsuits resulting from accusations of sexual harassment, wrongful termination, or employment discrimination.

Business interruption insurance – Covers lost income due to interruption in normal operations from a variety of factors.

Licensing coverage – An add-on to professional liability insurance that covers expenses if the insured becomes subject to a hearing before the licensing board in your state.

Money and securities coverage – Covers loss of money from the business premises; can also cover money while it's in the possession of a messenger.

Valuable papers or records coverage – Covers important papers such as mortgage deeds or loan documentation, so long as they're kept under lock and key.

Outdoor sign coverage – Covers damages to signs, both while it's in place and if it's been taken down for any reason.

Umbrella coverage – Provides coverage in the event that other claims limits have been exhausted for ordinary liability policies, or if a situation arises that is excluded from other liability policies.

Workers Compensation – Required on a state-by-state basis and subject to state regulations. Generally required of all employers. In some states, employers under a certain size are exempt (usually employers with fewer than three, four, or five employees). Covers employees' medical and rehabilitation expenses, as well as their lost wages resulting from an on-the-job injury.

CHAPTER 11: CRIME INSURANCE

INTRODUCTION

THE NEED FOR CRIME INSURANCE

The four most serious violent crimes are homicide, forcible rape, robbery, and aggravated assault. The three most serious property crimes are burglary, larceny-theft, and motor vehicle theft. These are referred to as "index crimes." This term applies because these crimes are serious, they are most likely to be reported, and therefore, they can serve as a valid barometer of changing patterns and trends in crime. The FBI's Uniform Crime Reporting Program (UCR) measures them each year.

The United States experienced its greatest increase in crime beginning in the early 1960s and continuing through the 1970s. This condition has been attributed to many causes, including judicial restraints on the police, the decline in capital punishment, the "pampering" of offenders, poverty, racism, the seemingly un-stoppable flow of drugs, and the rise of violent television programs.

This is not a circumstance unique to the United States alone. Except for homicide, most industrialized nations have crime rates that resemble those in this country. In 1981, the burglary rate in Great Britain was much less than that in the United States. Within six years, the two rates were near equal.

The United States, however, continues to lead the industrialized world in murders. This may be partly attributable to the greater availability of handguns; however, handguns are not the only cause. Our country has always had a violent history with respect to murder.

It has been reported that nearly one fourth of all property crimes committed are burglaries.

Approximately one out of every 117 registered motor vehicles is stolen each year. This is primarily a big city problem, worsened in recent years due to the phenomenon of carjacking.

Victims of larceny and theft crimes lost an estimated $4 billion in 1995, yet many other theft crimes went unreported.

With the exception of homicide, crime rates have been decreasing over the past decade. In the United States, we now have a slightly declining rate of property crime. Robbery rates have declined 15 percent. Even with regard to homicide, there is relatively good news: in 1990, the rate at which adults killed one another was no higher than it was in 1980, and in many cities, it was considerably lower.

Two things happened which may have reduced these forms of crime. The first was that the postwar baby boomers passed into middle age. By 1990, there were 1.5 million fewer boys between the ages of 15 and 19 than there were in 1980.

In addition, there was a greater increase in the size of the prison population, caused in part by the greater willingness to send offenders to jail. Until about 1985, there were almost exclusively "hardened" criminals and parole violators behind our prison walls. It is held that the combined effect of fewer young people on the street and more offenders in prison contributed to the decline in crime.

However, the rate of youthful crime has increased. A researcher at Carnegie-Mellon University has estimated that the rate at which young males, ages 14 to 17, kill people has risen considerably for White people and even more so for Black people. Between 1985 and 1992, the homicide rate for young White males went up almost 50 percent. For young Black males, it tripled.

Today's crime problem is different from and more serious than that of earlier decades. Youngsters are shooting at people at a far higher rate than at any time in recent history.

Since young people are more likely than adults to kill strangers (as opposed to family members or spouses), the risk to innocent bystanders has grown dramatically.

Through the study of criminology, we know much about the characteristics of young people committing crimes. Generally, they come from emotionally distant or abusive families. They typically have a low verbal intelligence quotient, do poorly in school, and tend to succumb easily to peer pressure.

They are impulsive, they begin their misconduct at an early age, often by the third grade, and they tend to abuse alcohol and drugs at early ages as well.

Early in this century, many Americans lived in poor housing conditions, and were illiterate. Wages were universally low and unemployment was extreme. However, crime rates remained low where traditional social elements of families, churches, schools, and values were strong. Our crime problems were aggravated when those factors lost their hold on the young.

It seems the answer to our crime problem is not an easy one. An effective anti-crime strategy involves our criminal justice system and an increased efficiency in which we channel our offenders, as well as finding strategies of intervention by families and communities.

CRIME COVERAGE POLICIES

Homeowner's Insurance

There are many types of crime coverage policies. One of the most common forms of insurance is homeowner insurance. This type of insurance is, in reality, a package policy with a combination of coverage.

This policy typically covers the home and its appurtenant structures from a variety of perils, such as fire, vandalism, burglary, robbery, theft, and malicious mischief. The property of the insured is likewise covered from these perils. In addition, the policy provides coverage for the insured's liability arising out of the covered premises and includes benefits to cover living expenses in the event the house becomes uninhabitable due to a covered peril.

Typically, under a homeowner policy the insured premises are the residence premises described in the policy declarations. The intent of the policy is to cover losses on the described premises and not on other premises rented by the insured or on business premises. The policy defines coverage in terms of a dwelling.

Coverage A—Dwelling

This policy covers the described dwelling building, including additions in contact therewith, occupied principally as a private residence. This includes all building equipment, fixtures and outdoor equipment pertaining to the service of the premises while located thereon or temporarily elsewhere.

It also covers materials and supplies located on or adjacent to the premises which are intended for use in construction, alteration, or repair of such dwelling.

In addition, coverage may further extend to appurtenant structures under the following provisions:

Coverage B—Appurtenant Structures

This policy covers structures, other than the described dwelling building, including additions in contact therewith, appertaining to the premises. This coverage also includes materials and supplies located on the premises or adjacent hereto, intended for use in construction, alteration, or repair of such structure.

This coverage excludes structures used in whole or part for business purposes and structures rented or leased in whole or part.

Generally, property structures are listed and scheduled on the policy, and coverage is clearly determined by inspection of the policy's declaration sheet.

Coverage C—Unscheduled Personal Property

This policy covers unscheduled personal property usual or incidental to the occupancy of the premises as a dwelling. The property must be owned or used by an insured while on the described premises, and at the option of the named insured, owned by others while on a portion of the premises occupied exclusively by the insured.

Phrases such as "household goods," "household furniture" and the like, cover a variety of articles, as long as the articles in question are chiefly associated with the household in their general nature and use.

On the other hand, coverage is normally denied where it appears that the articles in question are not ordinarily associated with the household. Objects purchased or brought on the premises after the inception of the policy are generally held to be within the coverage of the policy terms.

Floater policies and endorsements provide coverage for specific goods or classes of property, which are easily moveable. All connotations and provisions of the policy to which they are endorsed govern such floaters.

Homeowner's policies may typically cover certain types of personal property on a worldwide basis, as in the nature of floaters. Floater policies are also used to cover mobile equipment, such as cranes and similar construction machinery, and may provide at-risk coverage to both the lessor and the lessee of the equipment.

However, floater policies may exclude coverage for equipment held in permanent storage.

Blanket coverage may be used to cover all items described in the policy, or the term may be used to describe a specific type of policy, such as a blanket crime policy, which covers a wide range of perils.

Reporting form policies are designed to provide more flexible policy limits than a standard policy. This is particularly helpful for insureds that have fluctuating inventories. They only pay premiums on the amount of coverage for the particular monthly period determined by a monthly inventory report, which the insured sends to the insurer.

This policy will generally limit coverage to the amount declared in the last report filed prior to the loss. Such a provision will still be operative despite the failure of the insured to file a report for the previous months in a timely manner. In such a situation, the insurer may look to the last report filed by the insured.

A jeweler's block policy, as understood by jewelers, insurance underwriters, and insurance companies and by the legislature, is not a combination of various risks united in one policy for convenience. In reality it is a completely different type of insurance.

It requires that the insured maintain detailed or itemized inventories so that the exact amount of the loss can be determined. The details may include a full and complete description of the property. The coverage may include property in transit by mail or armored car service, property on deposit in a safe/vault at a bank or in a safety deposit box, or property in the custody of another dealer or selling agent.

Certain states have valued policy laws, which provide that, in case of a total loss, the recovery will be the amount of the policy limits. In some circumstances, deductions may be made for depreciation of the insured property. The same results may be achieved by certain policy language, which schedules personal items. Upon the loss of such an item, the scheduled amount is deemed to be the amount of the loss.

Policies often require that the insured take necessary steps to protect the insured property after a loss occurs. Similarly, the policy may be issued on the basis of assurances that the insured will install or maintain protective safeguards which lessen the risk of loss.

Such provisions are valid and enforceable and may require the insured to use due diligence to exercise all necessary precautions, or to use reasonable care. For example, where a burglar renders a burglar alarm inoperative, coverage will exist for the loss. The insured may be required to maintain records to show that the system was repaired.

This type of policy may exclude loss where the insured fails to exercise reasonable means to preserve the insured property after the loss. The insured's failure to preserve and protect the insured property is generally a question of fact for a jury. However, where the insurer has the option to repair or replace the damaged property, the insured may be relieved of his duty to protect the property.

Tenants (Renters) Insurance

The tenant, or lessee, of any property has an insurable interest in the improvements and betterments that he makes to the leased premises, at least for the duration of the lease. In addition, the tenant has an insurable interest in buildings erected by him on the leased premises, even though he may be prevented from removing such buildings if they become the property of the lessor at the expiration of the lease.

A tenant may elect "tenants," or "renters," personal property coverage, similar to homeowner insurance coverage, only without the coverage of the structure. The renter may insure his personal property, which is incidental to the occupancy of the premises.

The insured may elect to cover "household goods" and "household furniture" as long as these articles are associated with the household in their general use. Coverage is not afforded where the articles are not ordinarily associated with the household.

Typically, this type of policy affords coverage to the personal property of others while on the portion of the premises occupied exclusively by the insured.

Further, a renter's policy also provides liability coverage and includes benefits for living expenses in the event the house or apartment becomes inhabitable because of a covered peril.

Automobile Insurance

Automobile theft insurance policies generally state that they provide insurance against loss resulting from "theft, larceny, robbery or pilferage." In addition, insurance against loss from theft is frequently provided in so-called "comprehensive" clauses of liability and collision policies.

The question of whether a loss within such provisions has occurred turns most often upon one or both of two factors: first, the nature of the taking, and second, the identity of the taker.

The courts hold that, in determining what losses fall within the coverage afforded by a policy insuring an automobile against theft, the provisions of the policy are to be construed according to the natural import of the language used. Any ambiguities in such language are to be resolved in favor of the insured.

Since automobile theft policies commonly protect the insured against robbery, pilferage, theft and larceny, these coverage terms need to be discussed.

Robbery, the courts have recognized, is a form of larceny. To recover insurance benefits for an alleged robbery of a car, all of the elements of the criminal offense of robbery must be shown.

Pilferage is synonymous with petty, or petite, larceny. Because of the nature of the crime of petty larceny and the restrictions with regard to value in connection with this crime, the theft of an automobile would rarely be within the scope of that term.

It is generally recognized that the theft is roughly, though not exactly, equivalent to a taking that would amount to the crime of larceny. To recover for an alleged theft, the insured has the burden of proving much the same facts that would be required in a criminal prosecution for larceny. Thus, he must show a felonious intent upon the part of the taker of the car.

The majority of courts have held that this intent must be an intent permanently to deprive the insured of his car. In accordance with the general rule that for the taking of personal property to amount to larceny, there must be proof that the taker had the criminal intent wholly and permanently to deprive the owner of his property.

The courts generally hold that there is no theft if it is shown that the alleged thief intended to return the car after using it temporarily. However, the mere fact that the taker of a car testified that he did not intend to steal the car, but instead, intended to return it, does not disprove the requisite intent to steal.

A temporary taking is held not to be a taking which is insured against. Courts have held to the contrary (that is, that for insurance purposes, a temporary taking may be shown to be a theft) and have stated various reasons for doing so. Generally, these are particularly applicable statutory provisions regarding the crimes of larceny and theft.

It is widely held that if there is a question of whether the requisite criminal intent on the part of the taker of the car has been established, this need not be proven beyond a reasonable doubt, but instead, by a preponderance of the evidence.

In accordance with the rule generally applied in larceny prosecutions, it is generally held that the taking of an automobile cannot result in a loss covered by a policy of theft insurance, unless the taking is nonconsensual.

The taking of a car by an insured's employee or bailee is frequently held to be consensual, and thus is not a theft. When the insured's consent to the taking of the car is an intent to give the taker not only possession of but also title to the car, it is held that there can be no recovery as for a theft.

On the other hand, when the insured delivers only possession of the car to the alleged thief, an ensuing loss is generally held to be covered by the policy.

An insurer's liability is not limited, under an automobile theft policy, to payment of the value of an automobile, which is stolen and then recovered. It extends also to damages or losses sustained by the vehicle after it is stolen and before it is returned to the owner.

Thus, if an automobile is stolen and wrecked by thieves, whether by collision or otherwise, and is rendered as having little or no value, there is liability on the part of the insurance company for the full amount of the loss under the theft coverage.

When an insured's automobile is damaged as a result of a collision while in the custody of a police officer that is returning the vehicle from the place where it was discovered after its theft, the insurance company is generally liable for the amount of the damage incurred, even though the policy excludes loss by collision.

Theft provisions of automobile insurance generally refer to the theft of the vehicle itself, and not to personal property contained in or on such vehicles. Where such property is insured against theft, such coverage generally is obtained in policies other than the automobile insurance policy, such as the homeowner policy, including floaters or endorsements thereto.

Such property also may be protected under the theft provisions of business or commercial policies. However, the theft provisions of such non-automobile policies frequently exclude coverage in situations where property is stolen from an unattended vehicle or, in many cases, where it is stolen from an unattended vehicle except for forcible entry into a locked, enclosed body or compartment, as evidenced by physical signs of such forcible entry.

Such policies may expressly extend to the transportation of personal property or property in the custody of an employee, such as a salesperson. Often they apply only while the property is actually under the protective custody of the insured's chauffeur or driver. Some policies apply only to the theft of the entire cargo and do not extend to pilferage.

The theft provisions of an automobile policy may also extend to the theft of property contained in the insured vehicle. There the policy does extend to the theft of property contained in a vehicle but is unclear as to whether it applies to any such theft or only to the theft when the vehicle itself is stolen, the standard rule of construction requiring ambiguous or unclear terms to be construed in favor of the insured will apply. Further, the coverage will typically apply where such property is stolen from the vehicle, but the vehicle Itself Is not stolen.

Frequently, some policies are issued to carriers, indemnifying them from losses of merchandise arising from theft. These policies may extend only to the theft of an entire shipping package. They may exclude pilferage and may also exclude theft by employees of the carrier. They may also exclude theft from unmanned vehicles, unless the vehicle is enclosed and fully locked, and there is visible evidence of forcible or violent entry.

Although automobile theft coverage customarily does not extend to the theft of personal property contained in an automobile, it often may cover "equipment" of the automobile. "Equipment" in this sense, means something designed for relatively permanent installation in the vehicle, and which cannot readily be utilized without being so installed. However, it is not limited to factory-installed equipment.

A policy may exclude from coverage the loss of particular types of property. Automobile theft insurance is universally viewed as furnishing protection only against losses arising from criminal takings of the insured vehicle.

Consequently, it is held that there can be no recovery under such a policy for a loss asserted to amount to a theft in the absence of proof of the existence of a felonious intent on the part of the taker.

Accordingly, there is no "theft" of an automobile when one takes it incapable of a criminal intent, or when it is taken by one claiming ownership of the vehicle, since in such a case there is total absence of criminal intent.

Furthermore, such intent must be shown to have accompanied the taking of the automobile, so there can be no theft, for automobile insurance policy purposes, where the alleged thief did not have a criminal or felonious intent with respect to the automobile at the time he took it.

Automobile theft insurance policies usually contain policy provisions expressly excepting particular losses from the coverage provided in the policy. A policy may specifically exempt from coverage theft when the automobile is used in an illegal activity.

Also, theft of an automobile through acts of a member of the insured's household is often expressly excepted from coverage in view of the fact that persons sustaining such a relationship to the insured have liberal authority to take possession of and operate motor vehicles of the insured, and they have unlimited opportunity for theft of such vehicles. Such exceptions have also been designed to prevent fraud and collusion by and between the insured and the persons in his or her household.

Under such member of household exceptions, various factors are considered in determining whether the taker of the automobile involved was a member of the insured's household. The term "household" is interpreted as pertaining to or belonging to the house or family who resides in the household of the insured. Thus, a nephew or an uncle may be a member of the insured's household under appropriate circumstances. When loss occurs while the vehicle is left unlocked contrary to the policy provision, the insurer is not liable for the loss.

Theft policies commonly contain some provisions requiring the insured to lock the automobile when unattended or to maintain and use adequate locking devices. A reduction in the amount of the premium affords a valid consideration for an agreement by the insured to keep his automobile locked when unattended. A stipulation to have and maintain a certain locking device and to "use all diligence and care in maintaining the efficiency of the locking device in locking the automobile when leaving it unattended" does not mean that the car shall never be left unlocked.

It does, however, require the exercise of due diligence and care — the diligence and care which one of ordinary prudence would exercise under the circumstances. Leaving a car unlocked and unattended in the street for at least five minutes breaches a warranty to use all due diligence by locking it when leaving it unattended.

A requirement that an automobile be left locked when unattended is not satisfied when the automobile is locked, but the key is left in the automobile. Also, leaving an automobile unlocked after dark on a city street with the motor running and the door open, although only for a few minutes, breaches the covenant to use all diligence and care in keeping the car locked when unattended.

The condition requiring one insuring an automobile to keep it equipped with a locking device and to use "all diligence and care in maintaining the efficiency" thereof, is breached when the insured fails, for a period of two weeks after the device becomes broken, to take any steps to have it repaired.

It is held that no recovery can be had for the theft of merchandise from the locked trunk of an automobile where, at the time, the automobile had been left in a garage with the doors unlocked and the ignition key in the switch.

Property Insurance

The principle may be generally stated that anyone has an insurable interest in property that derives a benefit from its existence or would suffer from its loss. Policies are maintained where it is clear that the insured has an interest, which would be injured in the event of the peril insured against.

Generally, there are two classifications of property insurance. "Direct loss insurance" offers coverage to the insured in the event of loss from damage, destruction, or theft to his property. "Liability insurance" protects the insured against damages for which the insured is legally liable.

In addition to perils of fire, casualty, disaster and theft, property insurance policies, or extended coverage provisions thereof, commonly insure against "vandalism" or "malicious mischief."

In ordinary usage, the word "vandalism" has been broadened in its meaning to include the destruction of property. Generally, the ransacking and destruction of an insured's personal property has been held sufficient to warrant recovery under a property insurance policy for damages resulting from "vandalism."

The term "malicious mischief" has been defined as an act done willfully and intentionally. In applying this term to particular acts, "malicious mischief," as used in property insurance policies, has been held to cover the systematic breaking of windows, doors, and fixtures.

Generally, it is unnecessary to distinguish between vandalism and malicious mischief for the purposes of determining coverage under property insurance policies. Some examples having been held as constituting vandalism and malicious mischief, within the meaning of property insurance policies, are: the damaging of washing machines in a coin-operated laundry, the damaging of a roof by children throwing rocks, the removal of air-conditioning units from apartments, the placement of poison near feeding cattle, the shooting of a dog, and the flooding of a building by trespassers.

Additionally, as a general rule, a landlord has an insurable interest in property leased. The areas described as insurable interest involve fixtures, chattel, and buildings upon the premises.

By definition, a policy of property insurance insures only the insured. Thus, a customer of an insured, for example, has no cause of action against the insurer for losses he may have suffered.

A policy may be worded, however, that more than one person is insured, and further, that the right of each insured shall be independent of the others so that the right of one insured is not prejudiced by the default of any other.

Guards with Respect to Property Insurance

A property insurance policy may commonly require, either absolutely or under certain circumstances, the presence of watchmen or armed guards. The insurer may require the employment of such guards to protect the insured building against burglary, robbery, theft, or vandalism. In such cases, the insurer may be liable for the expenses incurred in employing such a guard. Such obligations are valid and binding.

Often, there are questions involving who the watchmen are, and also there are questions regarding the degree of compliance with such provisions. There are questions of what constitutes a "continuous watch" or a "night watch."

The primary and controlling issue is determining whether a person is a watchman and whether he is employed and acts as such, as required by the terms of the contract of insurance. The compensation he is paid and whether or not he is called a "watchman" are not material.

The purpose of a watchman provision in a policy of insurance includes the protection of the insurer from fraud, as well as the protection of the property from the peril against which it is insured, such as burglary, robbery, theft, or fire.

To constitute a watchman, it is necessary that the person have the duty of watching. The mere physical presence of a person on the premises, even though continuously, does not constitute him a watchman when he has no duty to watch. For this reason, one who sleeps on the premises is not a watchman kept there at night.

It is essential that the watchman be under the duty to watch at the time in question. During the hours when he is not required to watch, it cannot be said that he is a watchman.

In some policies, the obligation to maintain a watchman arises only when the plant is shut down or idles.

Premises on which a large number of people are employed, but are not "open for business," eliminate the necessity of a watchman.

A temporary absence of a watchman is sometimes held immaterial on the theory that it occurred without the knowledge or consent of the insured and that the insured had fully complied with the agreement to keep a watchman on the premises whose competency and fidelity he had no occasion to distrust.

The fact that the watchman is negligent in the performance of his duty does not breach the obligation of the insured to maintain a watchman, at least where the insured has no reason to expect that the watchman would not perform his duties properly.

Accordingly, a warranty that a watchman is kept on duty at night is not broken when, without the employer's knowledge, the watchman goes to sleep during the time he should be on duty.

There is by definition a breach of the insured's obligation to maintain a continuous watch when he makes arrangements only for a casual or intermittent watch of the insured property.

In some instances, the policy provision requires the presence of an employee of the insured, or a "custodian," in addition to the presence of a watchman.

The term "during the night" means throughout the night, when used in connection with keeping a watchman.

It is not required that a watchman have only duties as such, nor that only one person be the watchman. Therefore, there is compliance with the requirement of maintaining a watchman where the duty of watching is placed successively on the various members of the crew.

Also, a watchman is not required to be exclusively a watchman, but the duty of watching must be a significant part of his duties. He is a watchman, even though he may be engaged in another activity.

The watchman must exercise such care and skill in the performance of his duty as are usually exercised by "reasonable, prudent and careful persons in watching similar premises."

Evidence of usage, that is, what is done in similar establishments, is often considered in issuing these policies. However, no greater duty exists as to the maintenance of watchmen than what is specified in the policy.

A watchman clause frequently may be eliminated by the payment of an additional premium sufficient to cover the risk.

Business Interruption Insurance

Business interruption insurance – sometimes-called use and occupancy insurance – is one of the newer forms of insurance to come into increasing use in recent years. As the name implies, this type of insurance is designed to protect the insured from losses arising from the interruption of his business.

Business interruption insurance does not have a fixed or single meaning and cannot be defined with precision. However, it may generally be described as a form of insurance designed to indemnify the insured against losses arising from his inability to continue the normal operation and functions of his business, industry, or other commercial establishment.

The insurer is liable, within the policy limits, for the insured's fixed charges and expenses necessarily continuing during the period of total or partial suspension of such business due to the loss, or loss of use of, or damage to all or part of the building, plant, machinery, equipment, or other physical assets thereof, as the result of a peril or hazard insured against. However, the insurer is liable only to the extent that these expenses would have been earned if the contingency causing the suspension had not occurred.

Particular matters or items which have been allowed as properly included in fixed charges or continuing expenses are: taxes, licenses, rent, insurance, telephone, lights, heat, power, payroll taxes, Social Security, payments to employees who would have been retained in any or all events, association and club dues which the insured customarily paid for certain officers, and the expense of maintaining a branch in another city.

The following items or matters have been said not to constitute fixed charges or continuing expenses: depreciation on the destroyed property, depletion, partners' drawing accounts where the insured was awarded a recovery for lost profits and such withdrawals were included in the net profit figure, and labor costs which were paid as a part of the property loss under another insurance policy.

It has commonly been provided in business interruption insurance policies that in the event of loss, the insurer would be liable for (in addition to lost profits, fixed charges, and continuing expenses) expenses necessarily incurred to reduce the loss. It has sometimes been stipulated that the expenses are payable only if incurred at the written direction of the insurer. Such policies have usually provided that the insured is required to use due diligence in the resumption of his business operations.

In recent cases involving business interruption insurance, it has been determined that its purpose is to protect the prospective earnings of the insured business. In determining the nature and extent of the business covered by the policy, the intention is to insure against loss from the interruption of the insured's business as a whole. The recoverable losses are not confined to a particular property described in the policy or to the exact operation or business in which the insured is engaged at the time the policy is written.

Recoveries have been allowed for lost profits from business activities, which were commenced after the issuance of the policy, and even for profits, which would have been earned by a new plant structure, which was not yet built, but would have been built during the suspension period. Recoveries have also been allowed where the business interruption resulted from the destruction of buildings not described in the policy but which were parts of the entire plant. Not surprisingly, business interruption insurance is also often termed "earnings insurance."

A business interruption insurance policy is generally in the form of a rider or endorsement on a policy insuring against loss or damage to physical assets as the direct result of the perils specified: often burglary, robbery, theft, or fire. Policy provisions, terms, and conditions, with respect to the perils insured against and notice and proofs of loss, are usually those contained in the policy to which the rider or endorsement is attached.

In the construction and interpretation of business interruption insurance, the rules applicable to insurance policies generally apply. The interpretation must be reasonable, and the contract should be interpreted to give practical effect to the intentions of the parties. In addition, the language must be given the meaning, which a person of ordinary intelligence would attribute to it. It should also be construed in favor of the insured if it is susceptible to ambiguous meanings. The loss should be determined in a practical way, having regard for the nature of the business and the methods employed in its operation.

The extent and computation of any loss, which may be recovered by the insured, are handled like many other types of property insurance. The insured's accounting practices and system are not controlling in determining the recoverable loss under business interruption insurance, but they are not irrelevant and should be given such weight as practical judgment dictates.

Business interruption policies may be "valued," in which the value of the loss is agreed upon in advance, and the amount to be paid by the insurer is fixed in the language of the policy. The determination of the amount of liability is a matter of mathematical computation. Where the property is valued and the parties have agreed upon the value of the insured's loss in advance, the amount fixed by the policy is ordinarily controlling.

In some states, laws referred to as "valued policy statutes" provide that the amount of insurance written is to be taken as the true value of the insured property in the event of a total loss. In the case of "open policies," the agreement of the insurer is to indemnify the insured, within the policy limits, for "actual loss." The amount of any loss sustained is not agreed upon in advance but is to be determined by competent evidence, the total being limited to the sum or sums specified by the policy. The question is one of fact, and the burden of the proof of the actual loss sustained is required.

Open policies have commonly provided for the recovery, during the time of the business suspension, of the insured's actual loss consisting of:

- The net profits thereby prevented from being earned (or gross earnings, less the cost of production of the merchandise sold),
- Fixed charges and expenses necessarily continuing during the suspension period to the extent that they would have been earned, and
- Expenses incurred to reduce the loss.

Profits and business expenses covered by this type of insurance should be determined in a practical way, with regard to the nature of the business and the methods employed in its operation. In such a determination, the insured's books and accounting systems are to be given consideration, but they are not controlling.

Also, in the determination of the loss, due consideration is given to the experience of the business of the insured before the event insured against and the probable experience thereafter. The indemnity has commonly been fixed on a daily basis of not exceeding 1/300 of the face amount of the policy or 1/365 in the case of a business, which operates on Sundays, and holidays. It is frequently provided that the insurer's liability for a partial business suspension is limited to a proportion of the liability that would have been incurred by a total suspension of business.

The insurer's liability during a time of partial suspension of business should be limited to the actual loss sustained, not exceeding that proportion of the per diem liability that would have been incurred by a total suspension of business, which the actual per diem loss sustained.

There is no prescribed or accepted formula for the determination of the actual loss of net profits and business expenses covered by such insurance except the test of past experience and the probabilities of the future. The insured should not be deprived of the indemnity merely because it is difficult to fix the loss with absolute precision.

Business interruption insurance policies have frequently contained coinsurance clauses, and these have been held enforceable in the absence of statutory prohibition. These, however, are subject to strict construction and the requirement of strict proof.

The period of time for which an insured can recover under a business interruption policy is primarily controlled and determined by the terms and conditions of the policy. While definite periods of time have sometimes been fixed during which the liability of the insurer would continue, the period for which an insured can recover under business interruption insurance is generally limited to the time required to rebuild, repair, or replace the destroyed or damaged property with the exercise of due diligence and dispatch.

Where the policy limits the liability to actual loss resulting from a business suspension due to a specified risk, the insurer is not liable, unless it is shown that the risk insured against directly produced the loss for which a recovery is sought.

The loss of profit and property usage has long been recognized as proper subjects of insurance. The peril insured against is a matter of contract, and may be whatever the parties agree upon, unless prohibited by law. While fire loss damage causing a business suspension has been the risk most frequently specified in these policies, other forms of business interruption may be insured against. Such things as explosions, riots and civil commotions, the elements, and damage from burglary, robbery and theft have been included.

It Is well settled, however, that the loss of or damage to physical property Is not covered by business interruption insurance policies; this is a separate interest, which may be specifically insured. In addition, the insurer is not liable except for losses directly caused by a risk insured against. An insurer is not liable for losses actually attributable to lack of demand for the insured's product, increased production costs, unfavorable business conditions and the like.

The terms and conditions of the particular policy ordinarily determine the Insurer's liability with respect to both the peril insured against and the amount and computation of any loss, which the insured may recover.

Marine Insurance

Probably the earliest record of marine insurance in America was a notice in the American Weekly Mercury by John Copson on May 25, 1721. He announced that at his house he had opened an "Office of Public Insurance on Vessels, Goods and Merchandise." This evolved because he and his associates had been obliged to turn to England, the home of marine insurance, for such coverage.

The first marine insurance company in the United States, the Insurance Company of North America, was established in 1792. By 1845, there were more than 75 American marine companies.

Because of the superb American clipper ships of that time, the marine insurance profession in America grew prodigiously between 1845 and 1860. Naturally, heavy losses were sustained during the Civil War. Other unfortunate turns resulted in the near demise of hull underwriting in the United States by the beginning of the twentieth century.

By the time of World War I, 65 to 75 percent of American marine insurance was placed abroad. In 1920, the American Hull Insurance Syndicate was founded. Today the American Hull Insurance Syndicate has more than 50 subscribing insurance companies, including many major foreign companies.

Marine insurance in 1840 was defined as "a contract whereby, for a consideration stipulated to be paid by one interested in a ship, freight or cargo subject to marine risks, another undertakes to indemnify him against some or all of those risks during a certain period or voyage."

The Marine Insurance Act was passed in 1906 to codify the laws of marine insurance. The Marine Insurance Act defines a contract whereby an insurer undertakes to indemnify the insured, in the manner and to the extent thereby agreed, against marine losses – that is to say, the losses incident to marine adventure. Prior to the passage of the Marine Insurance Act, the law of marine insurance in England rested almost entirely on common law or recognized commercial usage.

In the United States, where there is no statute codifying the law relating to marine insurance, this still remains the position.

There are two kinds of Admiralty libels: *in personam* and *in rem*. The *in personam* suit is against a named individual. In cases involving the *in rem* suit, the claimant is entitled to arrest the ship or other property and to have it detained until his claim has been decided or acceptable security has been given in lieu.

Federal district courts are given "exclusive original cognizance of all civil causes of Admiralty and Maritime jurisdiction." Usages and practices vary greatly in the United States. East and West Coast practices differ, while on the Great Lakes, long-established customs are recognized and accepted. In the study of marine insurance, one must become familiar with certain terms:

Marine Adventure

There is a "marine adventure" where:

- Any ship, goods, or other movables (insured property)are exposed to maritime perils;
- The earning or acquisition of any freight, passage money, commission, profit or other pecuniary benefit, or the security for any advances, loan, or disbursement, is endangered by the exposure of insurable property to maritime perils; or
- The owner of, or other person interested in or responsible for, insurable property, by reason of maritime perils, may incur any liability to a third party.

Insurable Interest

Every person has an "insurable interest" that is interested in a marine adventure. A person is said to have an interest in a marine adventure if he stands in any legal or equitable relation to the adventure, or to any insurable property at risk therein, and as a consequence of which, he may benefit from the safety or due arrival of insurable property, or may be prejudiced by its loss or by damage thereto, or by the detention thereof, or may incur liability in respect thereof. If the insured does not have an insurable interest, the insurance normally has no legal status.

Ship

The term "ship" includes the hull, materials and outfit, and stores and provisions for the officers and crew; and in the cases of vessels engaged in a special trade, ordinary fittings requisite for the trade; and in the case of a steamship, the machinery boilers, coals, and engine stores if owned by the insured.

Freight

The term "freight" includes the profit derivable by a ship owner from the employment of his ship to carry his own goods or movables, as well as freight payable by a third party, but it does not include passage money.

Goods

The term "goods" refers to goods in the nature of merchandise and does not include personal effects or provisions and stores for use on board. The marine insurance policy shall specify the name of the insured; the subject matter insured and the risk insured against; the voyage, or period of time, or both, as the case may be, covered by the insurance; the sum or sums insured; and the names of the insurers.

Most marine insurance contracts are affected through brokers acting on behalf of the insured. In many instances, the policies are issued in the broker's name "and/or as agent."

American cargo policies usually contain a brokerage clause specifying as a condition of the policy, that the insured's brokers, or any substituted brokers, shall be deemed to be exclusively the agents of the insured and not of the company in any and all matters relating to or affecting the insurance.

In the United States, agents are often appointed and licensed by cargo underwriters. This differs from the broker, who is the agent of the insured. This distinction is important because a notice given to an insured's broker is binding on the insured, but this is not necessarily the case if the notice is merely given to an agent of the cargo underwriters. This position is often complicated in some parts of the United States where insurance brokers are referred to as insurance agents, a confusing misnomer.

While most marine insurance on vessels is written under time policies, usually 12 months in duration, most insurance on cargo in the United States is written under open policies, or open covers.

These are not to be confused with floating policies, which describe the insurance in general terms, leaving the particulars to be defined by subsequent declarations. Floating policies differ from open policies in that they are affected for a specific amount, which is drawn upon until it is exhausted.

Open policies, widely used in the United States, are usually not stated for a specific period of time and may remain in force indefinitely or until canceled. Successive shipments are reported, or declared, and the insured has automatic coverage (within the terms, conditions and limitations stated in the open policy).

All shipments must be declared as soon as practicable, but unintentional failure to do so does not void the insurance. Open cargo policies are tailored to the insured's particular business and include a schedule of premium rates, which are based on the insured's experience and record.

There are many different types of insurable interests:

- Impractical and contingent interests are insurable.
- Partial interests of any nature are insurable.
- The lender of money on bottomry has an insurable interest with respect to the loan.
- The master or any member of the crew of a ship has an insurable interest with respect to his wages.
- The person advancing the freight has an insurable interest, insofar as such freight is not repayable in the case of loss.
- The insured has an insurable interest in the charges of any insurance, which he may affect.
- The mortgagor has an insurable interest in the full value thereof, and the mortgagee has an insurable interest in respect of any sum due or to become due under the mortgage.
- A mortgagee, consignee or other person having an interest in the subject matter insured may insure of and for the benefit of other persons interested, as well as for his own benefit.

The owner of insurable property has an insurable interest in respect of the full value thereof, notwithstanding that some third person may have agreed or be liable to indemnify him in case of loss.

It is usual for mortgagees to be named as joint insureds.

Types of Contracts Covering Sales

It is important to understand the various types of contracts covering the sale of goods:

F.O.B. (Free on Board)

Under this term, the seller quotes a price covering all expenses up to, and including, delivery of the goods upon the vessel provided by or for the buyer at the named port of shipment. *F.A.S. (Free Alongside*)

Under this term, the seller quotes a price including delivery of the goods alongside the vessel and within reach of its loading tackle. Thus, the shipper's interest ceases when the goods are delivered to the dock where the vessel is or will be docked.

C. & F. (Cost and Freight)

Under this term, the seller quotes a price including the cost of transportation to the named point of destination. Here the seller is not required to furnish the buyer with a policy of marine insurance. The seller is required to give "such notice to the buyer as may enable him to insure during transit."

The buyer may arrange insurance for his own interest. In these circumstances, the seller may be without insurance coverage during the period from the commencement of the risk until the acceptance of the documents of title by the buyer. To overcome this situation, the shipper may affect the seller's interest insurance.

C.I.F. (Cost, Insurance, Freight)

Under this term, the seller normally quotes a price including the cost of the goods, the marine insurance, and all transportation charges to the named point of destination. The seller must provide the buyer with a policy that protects the shipment from the time the buyer has an insurance interest until the buyer's interest ceases.

It is usual for policies of marine insurance to be valued, but unvalued policies are sometimes written, and there are rules to be followed in computing the insurable value.

Subject to any express provision or valuation in the policy, the insurable value of the subject matter insured must be ascertained to include the insurable value at the commencement of the risk, of the ship, including her outfit, provisions and stores for the officers and crew, money advanced for seamen's wages, and other disbursements (if any) incurred to make the ship fit for the voyage, plus the charges of insurance upon the whole.

Another consideration is the insurance on freight. Whether paid in advance or otherwise, the insurable value is the gross amount of the freight at the risk of the assured, plus the charges of insurance.

In insurance on goods or merchandise, the insurable value is the prime cost of the property insured, plus the expenses of and incidental to shipping and the charges of insurance upon the whole.

In insurance on any other subject matter, the insurable value is the amount at risk of the insured when the policy attaches, plus the charges of insurance.

All leased equipment is to be considered part of the subject matter insured and included in the agreed value. Conversely, it is stipulated that cargo containers, barges and lighters shall not be considered a part of the subject matter of the insurance.

Generally speaking, the insurable value is the value of the vessel and the commencement of the risk, including fuel, provisions, and stores. In cases of vessels engaged in a special trade, the value of any equipment required for that trade should also be included.

Ship owners often maintain their hull valuations at levels which are much higher than the current market value of their vessels. In times of rising freights, vessel valuations respond very quickly, and it is not desirable for an annual policy to be altered frequently to reflect such changes.

Conversely, in falling freight markets, advances, or loans on the security of a vessel might still be outstanding, and therefore, insurance for the original sum would still be required.

A valuer's estimate of the value of a vessel is based chiefly on comparison of prices obtained in the market for similar vessels. This does not necessarily represent the value of a particular vessel to her owner. The value in the owner's books does not even necessarily represent the true value. In fact, it is quite difficult to say what the true value of any vessel is to her owner.

American open cargo policies contain a Limits of Insurance clause, which limits the amount covered on any one vessel or in any one place. There are also limitations in respect to shipments stowed on the deck of any one vessel.

When the value of the goods shipped exceeds the amount stipulated in the policy, the principle of coinsurance applies.

Further, an accumulation clause also limits the amount recoverable under a policy. If there is an accumulation of interests beyond the limits expressed in the policy by reason of an interruption of transit or occurrence beyond the control of the insured, the insurer shall, provided notice is given as soon as is known to the insured, be liable for the full amount at risk. However, in no event shall it exceed twice the policy limit.

A contract of marine insurance is a contract based upon the utmost good faith, and if either party does not observe the utmost good faith, the other party may void the contract. Before the contract is concluded, the insured must disclose every material circumstance known to him, and he is deemed to know every circumstance, which in the ordinary course of business should be known to him. Failure to make such disclosures entitles the insurer to void the contract.

Further, all representations made during the negotiations of the contract of insurance must be true if they are material to the risk. Distortions are known misrepresentations or concealment. Misrepresentation is a false representation of a material fact, by one of the parties to the other, tending directly to induce the other to enter into the contract, or to do so on terms less favorable to him when he otherwise might demand terms more favorable to himself.

A material misstatement by the insured through misconstruction of information is misrepresentation. Omitting or failing to state a material fact is concealment.

Nondisclosure, whether fraudulent or innocent, strikes at the very basis of the contract, for the risk accepted by the insurer is not what he contemplated. The Marine Insurance Act states that every circum-stance is material, which would influence the judgment of a prudent insurer in fixing the premium or in determining whether he will take the risk.

In the absence of inquiry from underwriters, the following circumstances need not be disclosed:

Any circumstance which diminishes the risk.

Any circumstance, which is known or presumed to be known to the insurer. The insurer is presumed to know matters of common notoriety or knowledge and matters which an insurer in the ordinary course of his or her business ought to know.

Any circumstance as to which the insurer waives information.

Any circumstance, which is superfluous to disclose by reason of any, expressed or implied warranty. A contract of marine insurance is deemed to be concluded when the insurer accepts the proposal of the insured, whether or not a policy is immediately issued.

Reference may be made to the application for insurance, often called a "binder," and this signifies the acceptance of the risk. This document must be carefully and accurately drawn to reflect the understanding reached between the underwriter and the insured (or the insured's broker).

A promissory warranty is a warranty by which the insured undertakes that some particular thing shall or shall not be done, or that some condition shall be fulfilled, or whereby the existence of a particular statement of facts is affirmed or rejected. The warranty must be exactly complied with, whether it is material to the risk or not.

The term "warranty" is frequently used in marine insurance clauses, though not all such references are true promissory warranties. They merely limit the scope of a policy. Thus, a warranty "free from capture and seizure" does not require the insured to undertake that the ship or cargo shall not be captured; it is merely a stipulation that the policy shall not apply to such a loss.

Institute Trading Warranties, which are customarily attached to the policy, limit the areas in which the insured vessel is permitted trade. A breach in this warranty would not result in the automatic termination of the policy but would merely call for an additional premium to cover the breach.

Underwriters place great importance in classification societies. These societies have rules regarding the survey and maintenance of vessels, and they require periodic dry dockings. In contemplating the insuring of a particular vessel, an underwriter will typically consult the Classification Society's Register for the rating of a vessel.

This rating is the determination of the relative state or condition of the vessel in regard to its insurable quality. He will base the premiums, in part, on the fact that a vessel is "fully classed," for example, "A-1 at Lloyd's."

In the case of older vessels, it is often warranted that a vessel must remain "in class," and that if for any reason the Classification Society withdraws her classification, the policy is void. When such a warranty is included in the policy, underwriters insist that the average adjuster obtain a statement from the Classification Society that the vessel has remained in class from the inception of the policy to the date of the casualty before settling any claim arising from such casualty.

The classification of ships is also important to cargo underwriters. When insuring for an open cover on cargo, an underwriter does not know which vessels will be carrying the goods he is insuring. The type, class, and age of the carrying vessel affect the premium to be charged, so open cargo policies contain a classification clause.

Such a clause describes vessels, which are not subject to additional cargo premiums, such as cargo liners and other vessels not more than 20 years of age and classed A-1 with the American Bureau of Shipping, or classed 100-A-1 with Lloyd's Register of Shipping. The clause goes on to list minimum additional premiums based on the age of the vessel.

In recent years, even cargo liners more than 15 years old have carried an additional premium. The result is that insureds under open cargo policies are reluctant to ship their cargo in vessels, which require cargo underwriters to levy an additional premium on the cargo being shipped. This, of course, is the underwriter's objective.

According to the Marine Insurance Act, in a voyage policy there is an implied warranty that at the commencement of the voyage, the ship shall be seaworthy for the purpose of the particular adventure insured.

The laws give wide extent to the implied warranty of seaworthiness. In the case of voyage policies, the insured is bound not only to have his vessel seaworthy at the commencement of the voyage, but also to keep her so, as far as it depends on himself and his agents throughout the voyage.

Most policies on vessels are now written for a period of time. Deviation or delay is excused in the following circumstances:

Where authorized by any special term in the policy.

Where caused by circumstances beyond the control of the master and his employer.

Where reasonably necessary in order to comply with an express or implied warranty.

Where reasonably necessary for the safety of the ship or subject matter insured.

For the purpose of saving human life or aiding a ship in distress where human life may be in danger.

Where reasonably necessary for the purpose of obtaining medical or surgical aid for any person on board the ship.

Where caused by the fraudulent conduct of the master or crew, if barratry is one of the perils insured against.

Once the "lawful excuse" ceases to operate, the vessel must regain her course "in reasonable dispatch."

In insurance on cargo, if the policy does not contain a clause extending the period of the coverage, and if the policy is caused from the loading thereof aboard the said ship, the risk does not attach until such cargo is actually on board, and the insurer is not at risk while the goods are in transit from the shore to the ship.

As cargo owners have no control over their goods once the vessel has sailed, insurance on cargo invariably contains a deviation clause. Under this clause, the insurance shall not be invalidated by any unintentional error in description of the vessel, voyage, or interest, or by deviation, over carriage, change of voyage, transshipment, or any other interruption of the ordinary course of transit from causes beyond the control of the insured. Any such error, deviation or other occurrence shall be reported to the company as soon as it is known.

Additional premiums must be paid, if required. The Warehouse-to-Warehouse clause in the basic cargo policy attaches from the time the goods leave the warehouse and/or store at the place named in the policy for the commencement of the transit and continues during the ordinary course of transit, including customary transshipment (if any) until the goods are discharged from the vessel at the final port.

Thereafter, the insurance continues while the goods are in transit and/or awaiting transit until delivered to the final warehouse at the destination named in the policy or until the expiration of 15 days (or 30 days if the destination to which the goods are insured is outside the limits of the port), whichever occurs first. This implies that any deviation from the ordinary course of transit would terminate the policy.

The intent of this clause is to extend the coverage for the entire period the insured is at risk, and if the risk extends from warehouse to warehouse, the policy covers. However, the controlling factor is the insured's insurable interest, which is governed by the terms of sale (discussed earlier).

The insured must give prompt notice to the underwriters where he becomes aware of any event for which he is "held covered." In practice, it is difficult for cargo owners to comply with the "held covered" provisions of the deviation clause. However, failure to report a deviation does not affect the coverage.

To deal with this problem, the Marine Extension clause was introduced into the policy by endorsement. This clause, in effect, overrides the Warehouse to Warehouse clause and the deviation clause in the basic policy, insuring coverage from warehouse to warehouse, provided that the goods are in due course of transit — that is, if there is no interruption of suspension of transit unless due to circumstances beyond the control of the insured.

Insofar as cargo consigned to South America is concerned, both the Warehouse to Warehouse and Marine Extension clauses are overridden by the South American Endorsement, which affords continuous coverage for 60 days (90 days on shipments via the Magdalena River) after completion of discharge of the vessel at the port of destination or until the goods are delivered to the final warehouse at destination. If the cargo arrives prior to the 60 days, the coverage ceases on arrival.

With regard to shipments to the Philippines, the Philippine Islands Endorsement overrides the Warehouse-to-Warehouse and Marine Extension clauses by limiting the insured to seven days after landing goods at the final port in the Philippine Islands. American underwriters do not often use this endorsement today since the congestion and general conditions in the Philippine Islands, which gave rise to its introduction, have since improved considerably.

A marine insurance policy is assignable either before or after the loss unless such assignment is expressly prohibited in the policy itself. Where the policyholder transfers his interest in the subject matter insured, he does not automatically transfer his rights under the contract of insurance, unless there is an agreement to that effect.

Further, once the insured has parted with or lost his interest in the subject matter insured, he cannot assign his interest in the policy. This does not prevent an insured from assigning a policy after a loss, provided he had an insurable interest at the time of the loss. Once a loss has occurred, the right to indemnity accrues, and this right can be assigned.

Thus, it is possible for an insured to sell the insured vessel in damaged condition and assign all claims existing at the time of the sale to the buyer. A marine insurance policy is freely assignable. The policy could follow the sale of the vessel and continue to cover it.

All marine insurance policies contain a Loss Payee clause. Under this clause, losses are only payable to the party or parties stipulated. No deviation is permissible unless the payees named voluntarily waive payment in favor of other parties.

The only exception to this is the provision that underwriters may pay claims to others as set forth in the Collision Liability clause. They may pay the surety if the surety has paid damages to any other person in respect to the collision.

This clause also specifically authorizes underwriters to make direct payments to anyone providing security for the release of the vessel in salvage cases. As a practical matter, the Loss Payable clause, in effect, makes the policy negotiable.

The premium is due on the completion of the contract and delivery of the policy. The insured, not the broker, is responsible for the payment of the premium. In the event of nonpayment of the premium 30 days after the attachment, or of any additional premium when due, the policy may be canceled.

The American Hull Institute War Risks and Strikes clauses state that the risks covered are those which the American Hull Institute clauses would cover but for the operation of the War, Strikes and Related Exclusions clauses. The War Risk clauses detail some of the war risks covered: capture, seizure, arrest, restraint, and detainment.

To conform to the marine form to which the war clauses are designed to be attached, the coverage of malicious acts or vandalism is qualified to the extent only that such risks are covered by the policy. Thus, barratry, even if malicious in intent, continues to be covered by the marine policy.

The Automatic Termination clause, which is included in all commercial war risk coverage, stipulates that the insurance is to be terminated on:

- The occurrence of any hostile detonation of any nuclear weapon of war or;
- The outbreak of war between any of the Great Powers (the United Kingdom, the United States, France, and Communist China). The United States government to cover American ship owners and shipbuilders provides war risk insurance.

Acts committed on board a ship by the crew or passengers and directed against the ship itself or against persons or property on the ship, cannot be regarded as acts of piracy. Even where the mutineers' purpose is to seize the ship, their acts do not constitute acts of piracy. The laws of a particular state may also govern piracy under a marine insurance policy.

The terms "pirates" and "piracy" include passengers who mutiny and rioters who attack the ship from the shore. In terms of marine insurance, piracy is restricted to acts committed on the high seas, which are limited to the open waters of the sea, as distinguished from the waters of ports, harbors, and bays.

The definition of piracy is important because this risk is removed from the marine policy by the War, Strikes and Related Exclusions clause. It is, therefore, a war peril.

"Barratry" includes every wrongful act willfully committed by the master or crew. The act has to be more than mere negligence; it must be an action of criminal intent. Barratry remains a marine peril, despite the exclusion of malicious acts or vandalism from the marine policy.

The term "assailing thieves" implies theft accompanied by violence and does not include clandestine theft. If the coverage of pilferage is required, it must be expressly mentioned in the policy. The peril of assailing thieves is limited to the theft of property or equipment on vessels taken by force and does not contemplate theft of the entire vessel.

Insurance on a small craft often emphasizes coverage by specifying "theft of the entire yacht" as an insured peril. This is because such vessels can often be stolen without any force or violence at all.

THEFT COVERAGE

Introduction

Insurance against burglary, robbery and theft must be given fair and reasonable interpretations to cover the risks, which the parties have; reason to anticipate and believe would be met by the policy.

The term "theft" should be interpreted as broadly and as liberally as possible to protect the insured. Theft is defined as to mean the taking of the property of another without authority.

Theft includes any wrongful deprivation of property of another, including embezzlement or swindling. Theft coverage under a homeowner policy is almost always limited to the property on the premises, and it may exclude property away from the insured premises.

However, the policy may be expressly written to include property which is away from the premises. Theft coverage for a dwelling may often exclude coverage unless the insured is residing therein. Theft policies frequently contain clauses excepting liability under certain circumstances.

An exemption of coverage for the loss of goods due to the dishonesty of employees of the insured relieves the insurer of liability for such acts.

However, the loss of diamonds obtained from the insured by a stranger through false representation has been held not to be within the exclusionary clause.

Theft policies do not typically cover a taking under a claim of ownership.

Robbery

"Robbery" is a greater crime than theft. It is the unlawful taking of property, of any value, by means of force or violence or by putting a person in fear.

Robbery policies frequently insure against loss by theft or larceny and embrace losses from false pretenses as well. Robbery policies frequently contain provisions requiring the insured to take certain specified precautions to avoid or discourage the commission of robberies.

Such conditions are particularly common in bank robbery policies. Prominent among such provisions are those extending coverage to robbery from safes or vaults while they are locked or if a certain number of custodians, employees or guards are present.

Larceny

"Larceny" is the wrongful or fraudulent taking and carrying away by any person the personal property of another, from any place, with a fraudulent intent to deprive the owner of his property.

Burglary

"Burglary" at common law is the breaking and entering of the dwelling house of another, with the intent to commit felony therein. Burglary policies cover loss and damage to property occasioned by burglary or attempted burglary.

A burglary policy may require that the insured exercise due diligence in maintaining an alarm system. Insurance issued under the Federal Crime Insurance Program is subject to a protective device requirement. Failure to keep the insured property within a designated area or place for safekeeping may preclude recovery.

Burglary policies commonly cover losses sustained by the insured, members of his family or members of the same household. Generally, it is the intent of the person involved which determines whether he remains a part of the household of the insured, in spite of his physical absence. Thus, it is possible to retain status as one of the household of the insured, although being physically absent.

Some policies of insurance may restrict the benefit of the coverage to permanent members of the insured's household, as distinguished from members thereof generally. In some burglary and theft policies, exceptions are made for loss caused by hostilities, riots, or civil commotions.

It is not uncommon for insurance companies to include in their theft or burglary insurance policies provisions restricting their liability to cases where there are some "visible marks" or "visible evidence" of the use of force or violence affecting a felonious entry. However, such requirements are not automatically read into a policy.

Such provisions are inserted for the protection of the insurer, and they clearly favor the insurer over the insured.

Burglary of safe policies also commonly requires visible marks upon the insured's safe. In some instances, the requirement of visible marks or visible evidence has been imposed in policies pertaining to the theft of property from an insured's automobile.

The determination of what constitutes visible marks or visible evidence, within the meaning of such a provision and where such marks or evidence must be located in order to satisfy the policy requirement, is to a great extent dependent upon the particular facts involved. For example, a burglary or theft policy requires that there must be visible marks of force or violence "at the place of entry" onto the premises.

This requirement has been held to have been complied with if the visible marks are on one of the outer doors of the insured's premises. However, if the only visible marks are those on the inside doors, recovery has been denied.

A visible mark at the place of entry means that there must be marks from which it can be properly inferred that they were made through intent to commit a felonious act.

Some insurers have added to their policies a force or violence provision, a further requirement that the forcible entry must be evidenced by "physical damage to the premises."

Many policies specifically exclude loss of property by "mysterious disappearance." Such a position would relieve the insurer of liability where the property was misplaced or lost by the insured and not as the result of the felonious acts of another.

There are provisions, which are designed to either extend or to limit the coverage under these policies. These policies may expressly restrict coverage arising at particular times or places, such as when the property is in the actual care or custody of the insured, in transit, in a specified building, in a safe or vault, or in the mail. An insurer may validly contract that the policy is only effective as to a particular place; that is, only while the property is on the premises specified.

Generally, there are provisions requiring the insured to deliver to the insurer any recovered or damaged property. Where stolen property, of which an insurer has paid the insured the indemnity provided in the policy, is recovered and the transaction has been entirely completed, the right of the insurer to the recovered property within the terms and conditions of the policy cannot be questioned.

Coverage exists where the insured is forced at gunpoint to cash checks or withdraw money for payment to a thief.

A policy may cover the theft of "securities" and may define what is meant by that term. Blank checks, "all negotiable or nonnegotiable instruments, or contacts representing either money or property" are considered securities.

The word "merchandise" is used in policies insuring proprietors against interior robbery of "money, merchandise and securities." Merchandise is defined as being customarily sold within the proprietorship.

In addition, these policies indemnify the insured for all damages, within the policy limits, for loss of money by robbery from messengers, loss of money when a custodian is kidnapped, loss of money by safe burglary (provided the safe doors are locked), and loss of money by burglary from within any night depository in a bank.

Policies are issued for the protection against robbery of payroll. Insurance against robbery from "any employee of the insured while acting as a messenger or paymaster," applies to an employee in charge of the payroll money, although he may not be the regular paymaster.

Whether or not property of third persons is covered by these policies depends upon whether the policy is so phrased as to cover the insured's property only, property for which the insured is liable or responsible for, or any property on the premises owned by the insured. In the absence of a broader express coverage, the policy insures only the benefit of the insureds with respect to property owned by them.

A lien holder may protect his interest by insurance, although the property, by definition, is owned by third persons.

A policy protecting from burglary, larceny and related offenses may require an entry with force and violence greater than that employed in any breaking in order "to effect entry." Common clauses are those requiring "forcible and violent entrance," a "forcible break or entry," the use of "violent and forcible means," a "felonious entry by force," a "felonious taking of property by violence," entry "by the use of tools or explosives," or similar expressions.

The fact that a thief obtains property through intimidation satisfies the criminal law requirement of a taking by force.

Safes

It is commonly a condition of bank robbery policies that coverage is afforded only in specifically described circumstances. Prominent among such provisions are those extending coverage to robbery from safes or vaults while they are locked.

The insurer's liability may be limited to property within a safe, vault or other designated container or place of security. A burglary policy provision covering loss of or damage to money, securities, and merchandise, including furniture, fixtures, and other property in the premises, occasioned by burglary or an attempt thereat of any safe or vault on the premises, does not cover loss of cash from the cash register, although an attempt is made on the safe.

Property in a safe, which, as evident from the policy terms, is intended to be covered, will be held covered. The only question is the amount of the insurance carried on the property in the safe and the premium rate thereon.

The words "fire and burglar proof" safe apply only to the burglarproof compartment in a safe and do not cover articles taken from within the safe outside such compartment.

The terms "chest" and "compartment" in a policy of burglary insurance issued to indemnify the insured against loss inside the chest or compartment of a safe are used in an alternative sense. Money or articles placed by the insured for safekeeping in either depository will be deemed as protected by the policy.

A policy of burglary insurance covering the burglary of the contents of a safe while it is duly closed and locked does not cover a loss where only a compartment was feloniously broken into while the outer door of the safe was unlocked and open.

The loss of money from an open safe is not covered by a bank burglary insurance policy covering loss from a locked safe opened by force or forcible entry. However, the taking of money by robbers from a safe, which has been unlocked in preparation for the transferring of money, is an insured risk.

Felonious entry into a safe by actual force and violence, as used in a policy of burglary insurance, excludes entry by manipulation through the agency of an employee of the insured.

Disappearance Coverage

Pre-1943 burglary and theft insurance policies occasionally contained provisions to the effect that the disappearance of an insured object would not be considered as evidence of a theft or burglary. The insurance companies varied widely in their requirements as to proof of theft.

Generally, these provisions were interpreted in favor of the insured, allowing him the proof of his loss by the use of circumstantial evidence. A mysterious disappearance was certainly one from which theft might be deduced.

The courts were readily accepting that the proof of the disappearance of insured property under mysterious circumstances was adequate to support recovery under a policy in which the insurer agreed to pay for the loss by theft.

In order to bring about a greater uniformity in adjusting practice and also to eliminate a source of policyholder dissatisfaction, the "mysterious disappearance" contingency clause was introduced into the standard form theft policy on April 19, 1943.

Many people thought that the presumptive mysterious disappearance clause was designed to broaden the coverage of the policy and to make it extend to losses, which would not have otherwise been covered. However, the clause was not intended to give more coverage, but rather it was designed to reflect what had long been the judicial view as to what kind of evidence was necessary to prove a loss within the coverage of a theft policy.

Today some policies actually include the term "mysterious disappearance" within the definition of theft. Others simply coordinate the contingencies covered by offering protection against loss by "theft or attempt thereat or by mysterious disappearance." The general rule is that the proof of mysterious disappearance alone suffices to enable the insured to recover, even without showing the probability of theft.

Mysterious disappearance, within the meaning of a theft insurance policy containing a mysterious disappearance clause, embraces any disappearance or loss under any unknown, puzzling, or baffling circumstances. Under a policy insuring against loss of property by mysterious disappearance, recovery is generally allowed where the article disappears from the place the insured left it.

Generally, proof of the disappearance alone establishes the insured's right to recover without showing a probability of theft.

Recovery is ordinarily disallowed where the insured has no recollection of when he last had possession of the article. These policies may allow for a presumption of theft; however, it is still necessary for a loss to be established. Thus, the words "mysterious disappearance" do not transform the policy into an "all loss" policy, one which covers lost or mislaid articles.

Extortion

Extortion is defined as the act or practice of obtaining money from a person by force or by illegal power. Extortion is the sort of criminal activity, which falls within theft insurance coverage, even where the policy does not specifically mention extortion. Consequently, insurers find it worthwhile to draft theft insurance policies to expressly exclude coverage of extortion payments or to attempt to obtain increases in insurance premiums for the coverage of such extortion payments.

Generally, in cases involving kidnapping and the taking of hostages in a plane hijacking, the insured may recover against the insurer under a theft policy for ransom paid in response to such extortion activities.

There is no obstacle to the insured's recovery where the policy states that the losses must occur while the property is on the premises of the insured. As long as the policy covers the sort of risk posed by threats of extortion, the insured cannot be denied coverage on the grounds that the ransom payoff occurred off the premises of the insured.

Forgery Insurance

The term "forgery," within the contemplation of a policy for forgery insurance, is roughly equivalent to an act which – under the criminal law – would consider the crime to be that of forgery. This crime is defined as the act of falsely or fraudulently making or altering a document. However, some policies contain their own definitions of that term. In these cases, the policy definition prevails.

Recovery is allowed where the evidence establishes a loss occasioned by forgery. Recovery is denied where the loss does not involve a forgery, such as where the false instruments are executed by the parties purporting to have made them. Like other forms of insurance contracts, any ambiguities are resolved in favor of the insured.

There is a fund, appropriated from the United States Treasury, which makes money available to the Treasurer of the United States for making settlement with the payees of certain checks drawn on the Treasury of the United States, which have been lost or stolen, and negotiated and paid, by the treasurer on forged endorsements. The claimant must show that: The check was stolen or lost without fault on the part of the claimant,

- The check was thereafter negotiated and paid on a forged endorsement of the claimant's,
- The claimant did not participate either directly or indirectly in the proceeds of such negotiations and
- Reclamation from the forger subsequent to the forgery has been or may be unsuccessful.

Certain papers used in commercial transactions constitute "securities, documents or other written instruments" that are used in Clause E of the standard bankers' bond. This clause insures banks against losses in case such securities, documents or other written instruments are counterfeited or forged. Cashier's checks, continuing loan guaranties, invoices, mechanic's lien waivers, automobile chattel mortgages and leasing agreements, shipper's memorandums, and telegrams are all documents which have been held to come under Clause E of the standard bankers' bond.

Automobile certificates of title and certified balance sheets are not within the coverage of Clause E.

Dishonesty and Fraud Insurance

Insurance against fraud is often found in the coverage of fidelity insurance, or a fidelity bond. The one issuing the bond is called the "insurer" or "surety," and these terms are often used synonymously. This type of insurance covers losses caused by "fraud or dishonesty" to an employer through the acts of an employee. The bond covering these losses is ordinarily held to extend beyond acts which are criminal.

The terms “fraud” and “dishonesty” are generally words which are given a broad meaning, and they are always construed most strongly against the insurer. These terms include any act showing a want of integrity or breach of trust, or an abstraction of funds, together with deceit or concealment.

The “abstraction of funds” or “wrongful abstraction” are terms defined as an unauthorized and illegal taking or withdrawing of funds or property from the possession and control of the employer, and the appropriation of such funds or property to the benefit of the taker, or to the benefit of another, without his knowledge and consent.

“Willful misapplication” means a willful, unauthorized, and illegal application of funds or property of the employer to the use and benefit of the bonded employee, or to the use and benefit of another with his knowledge and consent with an intent to injure or defraud the employer. “Funds” do not necessarily mean actual cash. Funds are a much more comprehensive term and may include other assets or property.

Mere negligence, a mistake or an error in judgment does not constitute fraud or dishonesty. However, by their express terms, some fidelity bonds cover losses resulting from the negligence of the bonded person. An act to be fraudulent or dishonest is one of “wrongful purpose and connotes immoral inclination.”

To constitute fraud or dishonesty, it is not necessary that the bonded person intend to benefit personally from his wrongful act or conduct. A breach of trust or an abstraction of funds, together with deceit and concealment, is fraud or dishonesty within the meaning of the bond, even though the act is performed for the profit of or in connection with another person.

There is some disagreement as to the insurance coverage of losses caused by acts of “fraud and dishonesty amounting to larceny or embezzlement.” Generally, the terms “larceny” and “embezzlement” are not construed in a narrow and technical spirit with specific regard for the criminal statutes of the state.

This would limit liability under the bond caused by the acts amounting to the crimes named. Instead, the terms are more often construed broadly in their general and popular sense; that is, the bond is held to cover any fraudulent appropriation of the employer’s property, although it may not amount to a crime.

A breach of the bond occurs when an employee fails to account for money which he is engaged in collecting and receiving for his employer, or where he fraudulently misappropriates, or assists in misappropriating, funds or property belonging to his employer. On the other hand, there is no breach of the terms of the bond if an employee becomes indebted to his employer through a mistake or carelessness with no intent to defraud, even though his act results in a loss to his employer.

The following section characterizes the more detailed aspects of these fidelity bonds.

Fidelity Bonds

A fidelity bond, or fidelity insurance, as the term is usually employed, is a contract whereby, for a consideration, one agrees to indemnify another against a loss arising from the want of honesty, integrity or fidelity of an employee or other person holding a position of trust. While the contract may resemble suretyship, it is generally held that guarantying the fidelity of employees or other persons holding positions of trust is, in effect, a form of insurance. Such a contract is subject to the rules applicable to insurance contracts generally.

The one who insures the fidelity of another is called the “insurer” or “surety.” For the one who insures the fidelity of an employee, his liability is primary and direct.

A fidelity bond must be issued for a lawful purpose; a contract guaranteeing the fidelity of one’s employees in an illegal pursuit is unenforceable. A fidelity bond issued to a foreign corporation, which has no right to do business in the state, is, likewise, invalid. Fidelity bonds partake in the nature of insurance contracts and are generally subject to the same rules of construction applicable to insurance policies. For example, ambiguities shall favor the insured.

The parties to a fidelity bond or policy have the right to write their own contract under whatever terms they require. Further, a fidelity bond is not binding on the insurer when not signed by the employee. The result of the absence of the required signature is that the surety is not liable.

A surety on a fidelity bond is liable for losses only where they are caused by the derelictions occurring within the period of time covered by the bond. The bond may validly limit the liability of the surety to losses occurring within a specified term or period of time. This practice thereby excludes liability for acts occurring prior to the effective date of the bond and acts occurring after the expiration of the bond.

Often fidelity bonds are issued to insure the integrity and honesty of officers and employees who are reelected or reappointed to their offices or employments. Where the officer or employee holds a continuous office subject to the pleasure of his superiors, it is held that the continuity of the office has not changed by his annual reappointment, so the bond covers him during the entire time that he, the officer, holds the office.

A different rule is applied where the contract of the parties evidences that the fidelity bond is limited to a particular term or time during which the bonded person holds the covered position.

The period covered by a fidelity bond and the renewals thereof depends upon the intention of the parties ascertained from the terms. The renewal of a fidelity bond constitutes a separate and distinct contact for the period of time covered. Some fidelity bonds contain provisions specifying the grounds for the termination of the bond. A clause may authorize the surety or the employer to terminate the bond on giving the other party a notice with a specified advance time. A clause may provide that the bond shall terminate upon the discovery by the employer of any act of infidelity or default on the part of the employee.

However, even the strongest suspicion does not amount to knowledge or discovery of dishonesty, and nothing short of the discovery of dishonesty, fraud or the positive breach of the imperative conditions will terminate the bond.

A fidelity bond insuring an employer against the dishonesty and/or fraud of a particular employee terminates upon the death of the employer, even though his executors continue the employer's business.

Nonpayment of the annual premium for a continuous contract bond does not terminate or invalidate the bond unless there is an express provision to this effect.

In order to hold a surety or insurer liable under a fidelity bond, the loss insured against must be caused by the person whose fidelity is insured and while he is acting in the particular capacity or position for which his fidelity is insured.

Fidelity bonds frequently insure an employer against losses caused by the wrongful acts or conduct of his "employees." The existence of an employer-employee relationship has been sustained where the insured has control over the activities of the alleged employee. If a person performs the duties of an employee, he is held to be an employee, within the terms of a fidelity bond, regardless of whether he is called an employee, agent, broker, salesperson, etc. Whether or not the parties have properly used the generic term "employee" is immaterial.

Ordinarily, the term "employees" applies only to those persons who are regularly and permanently employed by the insured employer as part of its force. It does not cover an employee of another company, for example, who at its direction merely reported to the insured temporarily for work, and then reported back to his own employer.

Generally, where a person occupies a dual position as employee of two or more entities, it is necessary to determine in which capacity he acted when he caused the loss by his misconduct or infidelity. If the loss occurs through acts performed under both employments, the sureties on the fidelity bonds to the different employers are jointly liable.

A corporate director is not an employee within a fidelity bond defining the term "employees" as "officers, clerks and other persons in the insured's direct employ." However, he is not necessarily excluded from the class of "employees" and can be covered by special wording of the policy.

In order that a surety or insurer may be liable under a fidelity bond, the loss suffered by the insured employer must have been caused by acts or defaults within the contemplation of the bond. The particular type of misconduct covered by the fidelity bond must be expressly specified, and the bond does not provide coverage for other kinds of misconduct not specified.

Ordinarily, a fidelity bond does not cover acts or defaults committed outside the scope of employment. Also, there is no coverage where an employee causes the employer loss in connection with a business other than the one which is designated in the fidelity bond. However, the fact that the employee committed the wrongful act after working hours does not preclude coverage for the resulting loss.

Some fidelity bonds limit their coverage to acts or defaults committed at a particular place or location. However, the fact that an employee works at a place other than that described in the terms of the bond does not preclude recovery where the contract permits "interchanges or substitutions among any of the employees."

Often fidelity bonds are conditioned upon a faithful discharge of duties covering losses resulting from negligence of the bonded employee. Even though a fidelity bond does not use the term "negligence," but does insure the faithful discharge of an employee's duties, it is held that if the employee, knowing the risk involved, fails to use such diligence in protecting the property entrusted to his care as should be used by an ordinarily prudent person, the surety may be held liable from the resulting loss. However, fidelity bonds conditioned upon a faithful discharge of duties do not provide coverage where the loss results from the incompetence of the employee.

Fidelity bonds cover losses caused by purposeful acts or conduct on the part of the bonded person amounting to fraud, dishonesty, larceny, embezzlement, wrongful abstraction, misappropriation, and the like. However, there is no recovery for these or similar acts when there is only a mistake, carelessness, or error of judgment on the part of the bonded person.

The general principles of concealment, representations, and warranties, which apply to insurance contracts generally, are applicable to fidelity bonds. For example, it is fraud for an employer, without making full disclosure, to apply for and accept a fidelity bond upon an employee whom he knows or believes to be untrustworthy or guilty of conduct which makes him unfit for a position of trust. Further, as a general rule, a surety or insurer on a fidelity bond is released from liability where the employer, in obtaining the bond, knowingly misstated facts or deliberately concealed them.

A fidelity bond may validly impose upon the insured employer the requirement of taking steps to bring about the prosecution and conviction of the defaulting employee and may make performance of such obligation a condition to recovery. Such a provision, however, requires only that the employer make reasonable efforts to bring about the prosecution and conviction of the defaulting employee.

If he has made such reasonable efforts he is entitled to recover on the bond, although no indictment is actually returned against the employee.

An insured employer under a fidelity bond cannot recover from the surety if he releases the defaulting employee from liability. For example, if upon discovery of default, the employer and employee, without the consent of the surety, enter into a new contact having resolved their differences, the surety is released from liability.

Even in the absence of an express provision in the fidelity bond, an employer who retains in his employment an employee who has been guilty of such conduct as constitutes a breach of the bond and conceals this fact from the surety cannot hold the surety liable for subsequent defaults of the employee.

Unless specifically stated otherwise within the terms of the bond, a material change in the nature of the duties of the person whose fidelity is guaranteed releases the surety from liability for acts committed after the change in his duties. However, this is distinguished from merely the addition of further duties to his usual tasks. If a crime is committed after the termination of a bonded person's employment, the surety is not liable, even if the conspiracy was formulated during his or her employment.

A fidelity bond may validly limit the surety to losses or defaults discovered within a specified time; for example, a specified time after the termination of employment or after the expiration or termination of the bond. No excuse is allowed for utmost diligence not being exercised in discovering the loss. Additionally, the employee allows no excuse that the discovery of the loss was prevented by fraudulent concealment.

Unless otherwise stated under the terms of the fidelity bond, the employer is required to provide notice of loss when he has actual knowledge of the loss or dishonest act. This is distinguished from the time the employer may merely suspect wrongdoing. The employer is required to be diligent in making discoveries or obtaining knowledge regarding suspected wrongdoing. The liability of the surety is generally reduced in the event the insured employer recovers any part of the loss.

Rules of Bailment

As a "bailment" is defined, it is the delivery of personal property by one person to another for a specific purpose with a contract, expressed or implied, that this trust shall be faithfully executed. The property is returned or duly accounted for by the bailee when the special purpose of the bailment is answered or is kept until the bailor reclaims it.

The principles of bailment were borrowed from the civil law, and the word "bailment" is derived from the French "bailer," meaning, "to deliver." "Bailee" is the term applied to the person who receives the possession or custody of the property, thereby constituting bailment. "Bailor" is the term given to the person from whom the property is received.

The only property that can be the subject of a bailment is personal property, including money, chattel, and personal belongings.

Some examples of particular classifications for transactions to which the law of bailment applies are:

- "Depositum," which is a deposit of goods to be kept for the bailor by one usually called a depositary. Custody, as opposed to service, is the chief purpose here. The depositary only holds the goods for safekeeping without any benefit to himself.
- "Mandatum," which is a delivery of goods to someone who is to carry or do something to them, but without compensation.
- "Commodatum," which is a lending or hiring of personal property to another with the property to be used by the bailee for his own pleasure or in his own business.
- "Pignori acceptum" or "vadium," which is the pawn or delivery of goods as security for a debt, where the title actually passes until the bailor reclaims it.
- "Locatum," which is the delivery of goods, always with reward, such as the bailee who gains temporary use of the thing.

Enacted by the Congress of the United States, the Consumer Leasing Act regulates contracts in the form of leases or bailments for the use of personal property for periods exceeding four months.

Here a consumer lease is defined as a contract in the form of bailment for a period exceeding four months and not exceeding $25,000, primarily for personal, family or household purposes.

Bailment for agricultural, business, commercial or governmental purposes are specifically excluded.

Each lessor is required to give the lessee, before consummation of the lease, a dated written statement with all pertinent information concerning the terms, including such things as the identification of the property, amount of money to be paid or to become payable, express warranties and guaranties, insurance requirements, security interests, and liabilities on the expiration of such. Penalties or other charges for delinquency, default or early termination may be specified in the lease.

The subject of bailment is strictly regulated by statute. The rights, duties, and liabilities of the parties to a bailment transaction, created by the deposit of personal property in a safe deposit box maintained by a bank, for example, is regulated.

Safe Deposit Boxes

Banks have the right to rent safe deposit boxes, vaults, and other receptacles as proper and legitimate banking transactions. However, the renting of safe deposit boxes is no longer peculiar only to banks.

Safe deposit or storage companies may also do it. Either way, it is always at the direct disposal of the customer, and its purpose is to furnish a safe place for the deposit of valuables.

This differs from the making of a special deposit for safekeeping, in which the bank assumes direct control over the deposit, usually in the bank's vault and together with other money, funds or property belonging to the bank. This special deposit is supposed to be kept separate and not commingled with other such property.

A safe deposit company or bank holds out to the public the implied agreement that property placed in its custody will be protected, so far as reasonable human foresight will permit, from the ordinary dangers to which valuables – whether in the shape of money, bonds, jewelry, and the like – are exposed.

With respect to property left in a safe deposit box, the safe deposit company is bound to exercise the degree of care which the law requires of an ordinary bailee in the keeping of valuable property.

This degree of care is also required in the selection of its employees and in the supervision of their conduct during employment. The company must exercise reasonable care and diligence, in view of the probable nature of the property deposited, in safeguarding the contents and in the prevention of theft.

The company, in renting safe deposit boxes, cannot exempt itself from the liability for loss of contents by its own fraud or negligence or that of its agents or servants.

Since safe deposit companies, banks and storage companies have provided their premises with individual receptacles, the keys to which may be retained by the depositors for a stipulated compensation, it is necessary to define the relationship between the parties with respect to the property and to the care, loss, or destruction during the terms of the contracts.

Where a safe deposit company or bank leases a safe deposit box or safe, the relation of bailee and bailor is created between the parties. The fact that the safe deposit company does not know the character or the description of the property in his possession does not change the relation.

The access to the contents of the safe deposit box can only be had by the use of a key retained by the lessee. The lessee of such a box is not bargaining for sufficient space in which to deposit his valuable property or money, but he is bargaining for safety, which the deposit company provides.

Further, the place where the property is deposited is always under some control by the deposit company, and it has absolute control at all times when the depositor is not at the box. If the depositor's own negligence contributes to a loss, the safe deposit company may not be liable.

Often two or more persons are leased one safe deposit box. Language of the contract will mandate "either or" or "joint" tenancy. Additionally in these circumstances, there must be provisions for the rights of survivorship.

Risk

All losses or risks may be insured against, unless contrary to public policy or statute. Risk is the essential element of any insurance policy. Within legal limits, the parties may make such contracts as they choose to qualify, limit, or expand on the risks involved. They may limit the risk by limiting the liability assumed in a variety of ways such as:

- The specification of amount of indemnity;
- The enumeration of certain perils;
- The exclusion of specified perils. The parties to the insurance contract have the right and the power to contract for whatever accidents and risks the insurer shall and shall not be liable.

The significance of the coverage of a risk by a policy lies in the fact that the insured cannot recover on a policy unless the loss is occasioned by one of the perils covered within the policy and within the limits of the policy. The recovery can be had only when the loss is covered by the policy or brought fairly within the terms of the contract.

Illustrating examples of risk, the liability on a fire policy is simply to indemnify the insured for any losses sustained by him through the burning of the insured premises. In the case of an automobile policy, the risk assumed may cover only a particular car. Indemnity is the object of insurance, so the insurer is liable only in cases where the perils fall within the risks insured.

Redlining

The practice of "redlining" was defined in 1982 by Springfield vs. McCarran as "discrimination based on the characteristics of the neighborhood surrounding the dwelling." It is the denial of home mortgage loans or insurance coverage in these areas based on geography rather than risk.

It is illegal but not uncommon. It evolved when financial institutions and insurance companies literally drew red lines around entire neighborhoods – usually poor and minority communities – deemed off-limits for loans and homeowner insurance.

A six-month inquiry examining banking, lending and home insurance coverage in poor and minority communities was made, based on more than 24 million mortgage records. More than 200 interviews were conducted in 12 cities.

The investigation discovered these principle findings:

- The number of poor and minority homeowners who cannot obtain full coverage property insurance is nearly 50 percent greater than for mostly white, middle-class areas.
- Poor Americans also pay more than twice, on average, than that of residents of middle class neighborhoods for property insurance.
- In high minority, low-income areas, residents pay an average of $3.21 per $1,000 more for homeowner insurance in comparison to residents of low minority, middle-income neighborhoods.

Crime is often higher in urban areas, making them riskier to insure. Insurance carriers often cite loss costs being demonstrably higher for these areas, accounting for more stringent underwriting rules and higher premiums.

Even so, a recent study done by the National Association of Insurance Commissions reviewed three decades of insurance industry performance in urban areas and concluded, "Insurance redlining is widespread and has adversely affected residents of poor and minority neighborhoods."

Civil rights groups have filed complaints accusing major insurance carriers of redlining, stating that the concept of "risk" is often used as an excuse for prejudice. Lobbyists for the poor have long claimed that this practice denies their clients fair access to the financial system.

Insurers deny that they redline as a matter of policy. A survey conducted by the American Insurance Association reached a similar conclusion.

The United States Department of Housing and Urban Development has formed a special task force to investigate redlining of homeowner insurance. The problem has gone on for decades and is nearly as old as urban America itself. Although the problem of redlining is common in both the banking and insurance industries, it is more prevalent with respect to mortgage companies.

This is, in part, due to the legacy of the 1945 McCarran Ferguson Act, which essentially exempted insurance companies from federal regulation. As a result, it has been left to the weaker state governments to try to stop redlining by the powerful insurance corporations.

Underwriting

"Underwriting" is the analysis of scientific information, and an "underwriter" is one who reviews and selects risks to be solicited or one who rates the acceptability of risks solicited. Underwriters often refer to their expertise as an art.

The underwriter is accountable to three entities: the company, the agent or broker, and the potential policyholder. The needs of all three must be balanced.

In 1960, the purpose of "reinsurance," or insurance on the insurer, was to share the risk on large and substandard cases. Reinsurance underwriters evaluated and rated these cases.

In the late 1970s, increased technical and actuarial involvement became necessary due to the rapidly growing industry and to increased competition. The cost of reinsurance protection became increasingly important, and these two processes, reinsurance, and underwriting, once the domain of the underwriter, became a joint effort.

Today, the underwriter's talent for review is often seen as secondary to the more actuarial and statistical position of the reinsurer.

Preventive Measures

Most insurance companies offer reductions in premiums to those who take preventative measures in keeping their homes, businesses, automobiles, and personal property secure. Keeping property secure causes a likeliness of avoidance of crime. It is well documented that education and preventative efforts can contribute toward substantial decreases in crime.

To commit a crime, a criminal needs two things: an opportunity and a victim. Some efforts for which insurance companies reward prevention with decreased premiums are keeping the home secure with deadbolt locks, window locking devices, special outdoor lighting and monitored alarms.

Automobile theft can be discouraged with the use of car alarms or supplemental security devices. Insurance companies often offer premium reductions for these devices. With regard to businesses or commercial properties, efforts such as security gates, deadbolt locks, and guards or guard services are often given premium reductions.

Neighborhood watch programs, which began in 1972, are shown to be effective crime deterrents. They offer a constructive way to channel anger over crime. Police departments and citizens' organizations suggest that promoting social interaction and fighting isolation may be the most effective weapon against crime.

There are further incentives for reducing crime. Building a new prison in the United States costs an average of $85,000 per bed and an additional $18,000 to $35,000 to keep one inmate in prison for one year. Often there is the added cost of welfare for the prisoner's family and the cyclical effect of generational behavior.

Crime Insurance Rating

The "rate" of the premium payable for the protection of indemnity provided by an insurance policy is expressed in the policy.

Ratemaking is a highly technical, scientific, and complicated process requiring much expertise.

Premiums are calculated based on a potential insured's needs and experience. Rates are determined by statistics collected by rate making service organizations whose primary purpose is to act as rating and statistical filing organizations for the purpose of rate making. They collect data and prepare the rates.

Member companies of these organizations report experience and loss and exposure data incurred under all policies. This experience, as well as other variables such as geography and need, serves as the basis for rate determination.

Then, discounts or additional charges may be included to compensate for the individual circumstances of risk. Thereby, insureds with good loss experience and limited exposure are compensated by receiving a credit (reduction) in their rates, and those with bad loss experience are penalized by receiving a debit (increase) to their premiums paid.

Generally, discrimination as to premiums between insureds of the same class is contrary to public policy, even though it may not be regulated as such by statute. Many states have statutes, which specifically prohibit discrimination as to rates, premiums, and dividends between insureds on risks of the same class. Here, rebates or other special inducements to procure insurance are also prohibited. However, the fixing of rates by the insured or by his agent or broker is not in violation of the anti-discrimination laws.

It may be a criminal offense to fix rates by agreement, conspiracy, or through a tariff association. This falls under the regulation of the Federal Sherman Anti-Trust Act, which prohibits restraints in trade or commerce.

Prior to any legislation on the subject, voluntary associations variously called "boards of underwriters," "rating bureaus" or "insurance exchanges" were frequently organized by insurance companies or agents for the purpose of securing uniformity in rates and premiums to be charged on different classes of property.

Today, rating organizations are generally regulated by statute and are frequently placed under the supervision of state officials.

These statutes outline in considerable detail the formation, duties, and powers of these rating bureaus, as well as the eligibility for membership. A state officer or a regulatory commission determines and fixes the rates, rather than merely approving schedules already filed by the insurance companies. Often the data submitted by the insurer or the rating bureau may be subject to audit.

The commission, then, may or may not approve the rate request. The purpose of the regulation of rates is defined as the promotion of the general welfare of all by preventing rates, which are excessive, inadequate, or unfairly discriminatory.

In order to control rates, the state may make the filing of rate schedules a condition precedent to obtaining a license to write insurance within the state. The state may establish or authorize the organization of a state rate board and may require rates to be submitted for review. They may even require insurance companies to organize and maintain or to become members of rating or actuarial bureaus.

Rate making is not essentially a judicial function, but where the duty imposed on a public official by statute is to establish a rate that is adequate, just, and reasonable, it is the duty of the court to see that this rate is promoted.

The insurers may obtain a judicial review of the rates fixed by a stated administrative officer upon showing that the rate set is confiscatory or fails to allow a reasonable profit. However, a rate is not confiscatory merely because it does not yield a profit to all insurers.

A court may review rates fixed by proper authority, but the court is limited to the act of reviewing and may remand the matter back to the administrative officer for further consideration or correction.

Rates, when fixed by the proper authority, are controlled and are not subject to modification by contract. The state may impose penalties for issuing policies at variance with those rates filed.

CHAPTER 12: TERRORISM & CATASTROPHE INSURANCE

Terrorism Risk Insurance Act (TRIA)

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Issue: Prior to the Sept. 11, 2001, attacks on the World Trade Center and the Pentagon, terrorism coverage was usually included in general insurance policies without an additional cost to insureds. After the attacks, coverage became prohibitively expensive, if offered at all. In response, the U.S. Congress (Congress) passed the Terrorism Risk Insurance Act (TRIA) in 2002.

TRIA was initially created as a temporary three-year federal program, allowing the federal government to share monetary losses with insurers on commercial property/casualty (P/C) losses due to a terrorist attack. Since then, it has been renewed four times: 2005, 2007, 2015, and 2019. The current reauthorization is slated to expire **Dec. 31, 2027**. TRIA requires insurers to make terrorism coverage available to commercial policyholders, but it does not require insureds to purchase it.

Background: Despite the terrorist attacks on the World Trade Center in 1993 and the Oklahoma City bombing in 1995, insurers did not view domestic or international terrorism as a risk that should be considered when underwriting commercial insurance policies because:

- Historic losses from terrorism were relatively small, and there was little data available to estimate future losses.
- Acts of terrorism are intentional acts designed to maximize damages and are not accidental insurable risks.
- Attacks are geographically concentrated in one area, making it difficult to spread the risk and increasing the chance of insurance company bankruptcies.

As such, terrorism coverage was an unnamed peril that was covered in most standard all-risk commercial and homeowners policies before the Sept. 11, 2001, attack.

The Insurance Information Institute (III) estimates that the 9/11 attacks cost the insurance industry $47 billion (in 2019 dollars) in losses, making it the most expensive terrorist incident in U.S. history, as well as one of the largest single insured loss events in history. Reinsurers covered about two-thirds of the losses. A breakdown of the losses by specifics includes 33% for business interruption, while 30% included property losses, including the World Trade Center towers. Workers' compensation, life, health, airline liability, and general liability insurance lines also paid out billions of dollars in claims.

After the massive financial losses from the 9/11 attack, reinsurers severely cut back on their terrorism coverage or stopped offering it altogether, putting a strain on U.S. insurers' ability to cover the risk. As a result, the companies that continued to offer terrorism coverage charged exorbitant premiums, making terrorism insurance unaffordable and unattainable for many.

Fearing future terrorism losses were unsustainable and uncertain of the large-scale risk, insurers defined terrorism as an uninsurable risk. In October 2001, the Insurance Services Office (ISO) asked all U.S. states for permission to exclude terrorism from all commercial insurance coverage. Ultimately, 45 states; Washington, DC; Guam; and Puerto Rico approved the new policy language, with the stipulation that workers' compensation insurance be excluded from the provision. Some terrorism coverage remained available in California, Florida, Georgia, New York, and Texas, as these states did not approve the changes to commercial policies. As a result of the terrorism exclusion, very few companies had protection against a terrorist attack a year after the 9/11 attacks.

Shortly thereafter, various industry groups called for federal intervention. The Terrorism Risk Insurance Act of 2002 was passed by Congress on Nov. 26, 2002, and signed into law by President George W. Bush.

The 2019 Reauthorization of TRIA

On Dec. 20, 2019, President Donald Trump signed into law the Terrorism Risk Insurance Program Reauthorization Act of 2019 (P. L. 116-94), which extended the Terrorism Risk Insurance Program (TRIP) for seven years through Dec. 31, 2027. The 2019 reauthorization:

- Requires the Secretary of the Treasury to include in its biennial report to Congress an evaluation of the availability and affordability of terrorism risk insurance, including specifically for places of worship.
- Requires the U.S. Government Accountability Office (GAO) to conduct a study on cyberterrorism risks, including an analysis of whether the states' definition of cyber liability under a P/C line of insurance is adequate coverage for an act of cyber terrorism, the potential costs of cyberattacks, the private market's ability to adequately price cyber risks, and whether the TRIA structure is appropriate for covering cyberterrorism.
- Adjusts the mandatory recoupment timing.
- Eliminates outdated language regarding past U.S. government reimbursement levels. The reimbursement level of covered terrorism losses exceeding the statutorily established deducible is now a fixed 80% as of Jan. 1, 2020.

The Terrorism Risk Insurance Act (TRIA) created a temporary federal program that provides for a transparent system of shared public and private compensation for certain insured losses resulting from a certified act of terrorism. The Secretary of the Treasury administers the program with the assistance of the Federal Insurance Office.

On November 26, 2002, President Bush signed TRIA into law.

On December 22, 2005, the President signed into law the Terrorism Risk Insurance Extension Act of 2005 (Pub. L. 109-144, 119 Stat. 2660) [TRIEA 2005]. TRIEA extended TRIP through December 31, 2007.

On December 26, 2007, the President signed into law the Terrorism Risk Insurance Program Reauthorization Act of 2007 (Pub. L. 110-160, 121 Stat. 1839) [TRIPRA 2007] which further extended TRIP through December 31, 2014.

On January 12, 2015, the President signed into law the Terrorism Risk Insurance Program Reauthorization Act of 2015 (Pub. L. 114-1, 129 Stat. 3) [2015 Reauthorization Act], which extended TRIP through December 31, 2020.

On December 7, 2016, Treasury published an interim final rule regarding the process of certifying an act of terrorism. On December 21, 2016, an additional final rule was published as part of Treasury's implementation of changes to the Program required by TRIPRA 2015. Treasury's regulatory actions and interpretive letters are contained on this website.

On December 20, 2019, the President signed into law the Terrorism Risk Insurance Program Reauthorization Act of 2019 (Pub. L. 116-94, 133 Stat. 2534) [2019 Reauthorization Act], which extended TRIP through December 31, 2027.

November 2020 Statute Pub. L. 116-92 – National Defense Authorization Act for Fiscal Year 2020 Requirements • Develop standardized definitions of terminology relating to domestic terrorism (DT) and uniform methodologies for tracking incidents of DT • This is requested to be done jointly by the Federal Bureau of Investigation (FBI) and the U.S. Department of Homeland Security (DHS), and in consultation with the Director of National Intelligence.

Under FBI policy and federal law, no investigative activity may be based solely on First Amendment activity. The FBI does not investigate, collect, or maintain information on US persons solely for the purpose of monitoring activities protected by the First Amendment. All personnel should exercise sound judgment and discretion in evaluating the totality of circumstances surrounding any of these indicators in order to determine whether a law enforcement or intelligence response or activity is warranted.

Definitions

Domestic Terrorism for the FBI's purposes is referenced in U.S. Code at 18 U.S.C. 2331(5), and is defined as activities:

- Involving acts dangerous to human life that are a violation of the criminal laws of the United States or of any State;
- Appearing to be intended to:
  - Intimidate or coerce a civilian population;
  - Influence the policy of government by intimidation or coercion; or
  - Affect the conduct of a government by mass destruction, assassination, or kidnapping; and
  - Occurring primarily within the territorial jurisdiction of the United States.

This is a definitional statute, not a charging statute. We talk about the threat these actors pose as Domestic Terrorism threats, but each of the FBI's threat categories, described in further detail below, uses the words "violent extremism" because the underlying ideology itself and the advocacy of such beliefs is not prohibited by US law.

In using the term Domestic Terrorism, DHS looks to the Homeland Security Act definition of terrorism, 6 U.S.C. 101(18), which is substantially similar but not identical to the title 18 definition. That provision defines terrorism as any activity that:

- Involves an act that:
  - Is dangerous to human life or potentially destructive of critical infrastructure or key resources; and
  - Is a violation of the criminal laws of the United States or of any State or other subdivision of the United States; and
- Appears to be intended:
  - To intimidate or coerce a civilian population;
  - To influence the policy of a government by intimidation or coercion; or
  - To affect the conduct of a government by mass destruction, assassination, or kidnapping.

In this vein, the FBI and DHS use the term Domestic Violent Extremist (DVE) to describe an individual based and operating primarily within the territorial jurisdiction of the United States who seeks to further their ideological goals wholly or in part through unlawful acts of force or violence.1 It is important to remember that the mere advocacy of ideological positions and/or the use of strong rhetoric does not constitute violent extremism, and in some cases direct or specific threats of violence must be present to constitute a violation of federal law.

Terminology

The US Government, including the FBI and DHS, continually reviews and evaluates intelligence to ensure it is appropriately identifying and categorizing a variety of national security threats to the Homeland. As part of this continual internal review, the FBI and DHS reconfigure broad threat categories as the threats evolve. While categories help the FBI better understand the criminal actors we pursue, we recognize actors' motivations vary, are nuanced, and sometimes are derived from a blend of ideologies. The categories also inform the intelligence and prevention efforts of DHS. Currently, the US Government broadly divides the DT threat among the following threat categories:

Racially or Ethnically Motivated Violent Extremism: This threat encompasses the potentially unlawful use or threat of force or violence in furtherance of ideological agendas derived from bias, often related to race or ethnicity, held by the actor against others or a given population group. Racially or Ethnically Motivated Violent Extremists purport to use both political and religious justifications to support their racially- or ethnically-based ideological objectives and criminal activities.

Anti-Government or Anti-Authority Violent Extremism: This threat encompasses the potentially unlawful use or threat of force or violence in furtherance of ideological agendas, derived from anti-government or anti-authority sentiment, including opposition to perceived economic, social, or racial hierarchies, or perceived government overreach, negligence, or illegitimacy.

Animal Rights/Environmental Violent Extremism: This threat encompasses the potentially unlawful use or threat of force or violence in furtherance of ideological agendas by those seeking to end or mitigate perceived cruelty, harm, or exploitation of animals and/or the perceived exploitation or destruction of natural resources and the environment.

Abortion-Related Violent Extremism: This threat encompasses the potentially unlawful use or threat of force or violence in furtherance of ideological agendas relating to abortion, including individuals who advocate for violence in support of either pro-life or pro-choice beliefs.

All Other Domestic Terrorism Threats: This category encompasses threats involving the potentially unlawful use or threat of force or violence in furtherance of ideological agendas which are not otherwise defined under or primarily motivated by one of the other Domestic Terrorism threat categories. Such agendas could flow from, but are not limited to, a combination of personal grievances and beliefs, including those described in the other Domestic Terrorism threat categories. Some actors in this category may also carry bias related to religion, gender, or sexual orientation.

Methodology: The FBI recognizes a Domestic Terrorism Incident as an ideologically-driven criminal act, including threats or acts of violence made to specific victims, made in furtherance of a domestic ideological goal, which has occurred and can be confirmed. A single incident may be comprised of a scheme or a serial criminal or violent activity conducted by the same perpetrator(s) using the same tactic(s).

The FBI recognizes a Domestic Terrorism Plot as a combination of criminal activity and planning that collectively reflect steps toward criminal action in furtherance of a domestic ideological goal.

Disrupted Domestic Terrorism Plots are plots which, in the FBI's assessment, absent law enforcement intervention could have resulted in a Domestic Terrorism incident.

The FBI makes every effort to proactively document lethal and non-lethal Domestic Terrorism incidents, but it is important to note there is no mandatory incident reporting requirement that mandates state and local law enforcement agencies to report criminal activity that appears to be ideologically-motivated consistent with the DT threat categories previously defined.

This makes it impossible for the FBI to ensure we have complete and comprehensive knowledge of any and all incidents of this nature that may take place across the United States. For example, if the FBI does not receive notification from state and local officials of an ideologically-motivated criminal act, especially one that did not result in injury or loss of life, the FBI may not know to include that incident in our records.

With an estimated $40 billion in insured losses as a result of the events of 9/11 the market for terrorism coverage became severely disrupted.

However, in addition to wanting to address Insurance industry disruptions, the Congress and the President recognized that such wide spread dislocations in insurance markets also had a negative impact on business' ability to finance economic activity and recovery.

TRIA was therefore enacted to stabilize the availability of insurance protection as well as to stabilize the overall economy. It effectively places the Federal Government temporarily in the terrorism risk reinsurance business.

The program provides coverage for commercial lines P&C losses including workers' compensation.

Coverage is triggered when the Secretary of the Treasury the Secretary of Homeland Security and the Attorney General together certify that an act of terrorism carried out on behalf of a foreign interest has occurred.

The terrorism-generated loss must be greater than $5 million and the event must have taken place in the US, or a US foreign mission, or on a US air carrier or vessel.

One of the first things that had to be defined under the act was what constitutes a P&C insurer.

This task was more difficult than it first appeared. However, "Insurer" for purposes of the act is:

- Any entity that is licensed or admitted for primary or excess insurance in any state;
- A surplus lines carrier on the quarterly NAIC listing of alien insurers;
- Insurers approved by a federal agency in connection with maritime, energy, or aviation activity;
- A State residual market or workers compensation fund;

Altogether well over 2000 insurance companies are participating in the program.

But understandably programs with current federal exposure like the National Flood Insurance Program are not included.

Also, insurance products including assumed reinsurance, health, and life insurance, and for now group life insurance are excluded from the program.

Like any program there are restrictions:

- Deductibles increase over the 3-year term of the program and are expressed as a percent of an insurer's direct earned premium;
- The Federal Governments share under the program is equal to 90% of that portion of insured losses that exceed the insurer deductible;
- While there is a cap on total insured losses, if total losses exceed the cap Congress will determine the procedures for and source of payments for those excess losses;
- The program was scheduled to end on December 31, 2005, but has been extended a number of times. The end date listed in 2025 is 2027.

Many believe that all federal programs last forever. However, the Former Riot Reinsurance Program and the Former Federal Crime Insurance Program are 2 examples of government insurance mechanisms that have been discontinued when it became clear that their temporary mission had been fulfilled.

There are provisions under the act whereby the Secretary can recoup certain government payments.

Mandatory recoupment is triggered whenever there is a loss and the insurance industry paid losses are less than that year's industry retention.

The annual industry retention is equal to the lesser of a dollar amount, which was fixed by Congress or the actual aggregate insured losses.

Aggregate Insured losses are all the losses associated with an act of terrorism that are within an insurer's deductible and the 10% of insured loss quota share.

Under mandatory recoupment The Secretary will establish Terrorism Loss Risk Sharing Premiums of up to a 3% surcharge on all commercial policy premiums. In addition, The Secretary can, depending on economic conditions, impose an additional discretionary recoupment program whereby additional surcharges on insurance premiums can be collected.

To illustrate let's assume there is a $20 billion covered loss during the 3rd year of the program. This Loss is greater than the insurance industry's maximum aggregate retention that year of $15 billion. Further assume that 100 insurance companies were exposed to that loss and that their collective direct earned premiums totaled $20 billion. The third year deductible of 15% equals $3 billion for these 100 companies and their 10% quota share equals another $1.7 billion making the 100 insurer's share of the total paid losses for the companies involved $4.7 billion.

Under this example the Treasury would pay $15.3 billion, which is the difference between the total insured loss and the losses paid by the 100 involved companies. However, under the law the Treasury is required to recoup $10.3 billion, which is the difference between the industry aggregate retention of $15 billion and the $4.7 billion paid by the 100 companies.

To accomplish this all companies covered under the program would impose up to a 3% premium surcharge on all commercial policyholders until $10.3 billion had been recouped and paid to the Treasury.

Additionally, depending on economic considerations the Secretary of the Treasury has discretionary authority to impose additional recoupment surcharges and could recoup up to the entire $20 billion loss.

The Terrorism Risk Insurance Program or T.R.I.P. is itself under the Treasury's Department for Domestic Finance and the Office of Financial Institutions.

TRIP's responsibilities include all of the operational functions necessary to effectively implement and manage the program, including all claims management and processing functions, as well as all auditing functions TRIP is in essence the insurance company created by the new law.

However, 2 additional Treasury offices play an important part in the program.

Treasury's Office of Economic Policy will be conducting studies associated with coverage issued under TRIA and the overall effectiveness of the program.

The office of Financial Institutions Policy is responsible for promulgating rules and regulations for the program and will continue to assist TRIP in rule making.

The Office of Financial Institutions Policy has been extremely active in implementing the regulations necessary to support the new act.

The final rule published in the federal register on July 1, 2003, sets forth key definitions that Treasury is using in implementing the program.

Among other things this rule addresses:

- Guidance on the Lines of Insurance covered under the act;
- Which entities are eligible for participation;
- Control and affiliation issues.

One of the most discussed issues in the new regulations was the definition of affiliate and what constitutes control. The issue is important because it goes to the heart of understanding the appropriate deductible to assign various affiliated insurance groups.

Conclusive Control Exists if an insurer has power to vote 25% or more of any class of voting securities of the other insurer; if an insurer controls the election of a majority of the Directors or Trustees of the other insurer.

Presumptive Control Exists if the Secretary of the Treasury determines that an insurer exercises a controlling influence over another insurer.

In determining presumptive control, The Secretary will consider approximately 11 other factors outlined in the regulations the presence of any 2 could lead to a determination of presumptive control.

Even though much has been accomplished, considerable work remains. Many in the industry have expressed concerns over such program issues as:

- Adverse selection;
- Continued lack of reinsurance availability;
- Huge exposures particularly in worker's compensation;
- Affordability.

When the President signed the Terrorism Risk Insurance Act legislation on November 26, 2002, whereby private insurers and the federal government share the risk of future losses from terrorism for a three-year period. With the President's signature, all state exclusions for terrorism were rescinded.

Insurers, over the period of the following 90 days, were required to notify existing commercial policyholders of the existence of the federal back top, offer comparable terrorism coverage and specify the cost of that coverage. Policyholders had the option to accept or decline the coverage, or negotiate other terms. These provisions applied to new policies written after enactment.

KEY BENEFITS

The bill brought a needed capacity back to the market at a critical time.

Without this legislation, insurers were looking at an almost incalculable risk. While still large, the potential risk to individual companies was quantified and enabled the market to function again.

The bill does not reestablish the status quo that existed before September 11. There has been a fundamental change in the nature of risk in our society – and the risk of further attacks is real.

The cost of terrorism coverage will depend on many factors over time, including whether or not there is another event.

Current market conditions will not change overnight. There will be added capacity, but individual companies will have to make decisions about the nature and amount of risk they want to insure.

The reinsurance industry took the most significant hit from September 11, more than half of the losses. They are not currently in a position to assume the same amount of terrorism risk as they were on September 11, which is why the federal backstop is critical.

Many small- and mid-sized businesses across the country will experience little change.

Their premiums are going up for other reasons, but the terrorism coverage itself will not add much to their insurance costs. The major problem remains the threat of chemical, biological, nuclear, and radiological attacks on high profile structures or businesses with large concentrations of employees. The bill helps make coverage available, but at least initially, it will be expensive.

MAJOR FEATURES OF THE LEGISLATION

An event has to cause $5 million to be certified as an act of terrorism.

Each participating insurance company will be responsible for paying out a certain amount in claims – a deductible – before Federal assistance becomes available. This deductible is based on a percentage of direct earned premiums from calendar year 2002.

The deductible is as follows:

2002 – 1 percent (from enactment through the end of the year)

2003 – 7 percent

2004 – 10 percent

2005 – 15 percent

For losses above a company's deductible, the Federal government will cover 90%, while the company contributes 10%.

If the Federal government pays for insured losses during the course of a year, the Treasury Secretary will be required to recoup the difference between total industry costs (individual insurers' losses up to their deductibles, plus the industry's 10 percent cost share above the deductibles) and the following fixed dollar amounts per year:

$10 billion for 2002 and 2003

$12.5 billion for 2004

$15 billion for 2005

Even with federal support, the insurance industry's share of the risk is substantial.

For example, assuming that the baseline for the program is $125 billion in commercial insurance (direct premium written) and that the next terrorist attack amounts to $30 billion in commercial property and workers compensation loss, the total industry loss would be approximately:

$11 billion for the remainder of 2002 and 2003 $14 billion in 2004

$20 billion in 2005

The recoupment will be accomplished through a surcharge on all policyholders. The surcharge cannot be more than 3% of the premium paid for a policy in a given year.

Losses covered by the program will be capped at $100 billion; above this amount, Congress is to determine the procedures for and the source of any payments.

The total insured loss for the World Trade Center, Pentagon and Pennsylvania events is $40.2 billion.

FLOOD INSURANCE

There is evidence that Flooding is by far the most common natural disaster type in the country, and flood is not covered by the typical homeowner insurance policy.

Flood insurance could be perceived as a solid hedge against the prospect of suffering a huge financial setback stemming from flood-caused damage to property. National Flood Insurance Plan coverage can protect the house, business, and possessions.

Another thing to understand is that if someone is in a high-risk flood zone, then a federally-regulated lender would require a would-be borrower to buy flood insurance in order to qualify for a mortgage loan.

How much coverage would be needed to satisfy a lender? The amount should at least cover the amount of the loan.

A homeowner should buy flood insurance if he or she resides in a known flood plain with no failsafe controls, like a dam.

Flood policies pay off even if the President doesn't declare the area to be a federal disaster area. The President very seldom declares an area a Federal disaster area, And if he did, the assistance would be in the form of a loan to be paid back at a later date.

With this in mind, flood insurance makes good sense.

One must be aware that not every home can qualify for flood coverage.

For instance, an individual might not be able to obtain flood insurance if their beach front or ocean-side property sits in an area prone to destructive hurricanes or thunderstorms.

One shouldn't wait until they hear it raining on their roof before they buy flood insurance. They can purchase flood coverage anytime, but the policy doesn't take effect for 30 days.

The Federal Emergency Management Agency (FEMA) reports that more than 19,000 communities have agreed to tighter zoning and building measures to control floods. Residents of these communities can buy flood coverage through NFIP, which FEMA oversees. NFIP has 4.4 million flood policies in-force nationwide.

Some NFIP underwriting particulars:

Limits coverage to $250,000 for the residential structure and up to $100,000 for contents.

On a nonresidential (commercial) structure such as grocery store,

As much as $500,000 for structure protection and up to $500,000 in contents coverage.

Renters can purchase contents coverage of up to $100,000 in limits.

Premiums "vary widely," depending on the individual risk.

In determining price flood insurance underwriters consider several factors including:

- A particular property's elevation;
- Proximity to bodies of water;
- Whether the dwelling has a basement.

The average flood insurance policy premium costs more than $300 per year.

Deductible sizes vary (e.g., $500, $1,000, $2,000, $3,000, $4,000, and $5,000).

Upwards of 200 private sectors insurance companies write and service flood insurance policies for the federal government, which funds the undertaking through flood insurance premiums paid by consumers.

FAIR PLAN

What if I can't get coverage for my home?

If an individual lives in a home that is considered "high-risk" or plans to move to a high-risk location, they may have difficulty obtaining an insurance policy.

What constitutes high-risk?

If the home is located in an area prone to severe weather such as hurricanes, windstorms, tornadoes, or hail.

If an individual lives in an urban area with high crime, vandalism, and theft.

If the home has an old plumbing, electrical and/or heating system, posing a higher chance of causing fire or water damages.

Georgia and New York provide wind and hail coverage for certain coastal communities.

In order to qualify for FAIR Plan coverage, the insured must: Make improvements that limit the risk of fire, theft, or water damage, such as upgrading your electrical wiring, heating, or plumbing systems, repairing your roof, or improving security.

If the insured does not correct conditions that make the home prone to losses, the FAIR Plan administrator has the right to deny insurance coverage.

Below are the states that offer FAIR Plan Insurance or assistance in getting coverage:

Alabama*	Indiana	Mississippi	Rhode Island
California	Iowa	Missouri	South Carolina
Connecticut	Kansas	New Jersey	Texas
Delaware	Kentucky	New Mexico	Virginia
District of Columbia	Louisiana	New York	Washington
Florida	Maryland	North Carolina	West Virginia
Georgia	Massachusetts	Ohio	Wisconsin
Hawaii	Michigan	Oregon	
Illinois	Minnesota	Pennsylvania	

Beach and Windstorm Plan

In seven Atlantic and Gulf states, there is a counterpart to the FAIR Plans called Beach and Windstorm Plans. They provide residents and business owners, in designated areas, with coverage against hurricanes and other severe windstorms. If two or more insurers turn down an individual, other options must be considered.

Most states have a special insurance plan known as shared market. Generally, two types of plans exist:

FAIR Plans

Fair Access to Insurance Requirements (FAIR) Plans were created in the 1960's to make insurance available in areas that had abnormally high exposure to risks over which they had no control. These plans are insurance pools that sell property insurance to people who can't get coverage in the voluntary market.

FAIR Plan policies may cost more than private insurance and may offer less coverage, but they offer insurance protection where none would otherwise exist. All FAIR Plans cover losses due to fire, vandalism, riot, and windstorm. About a dozen states have some form of a standard homeowner policy, which includes liability. In California, the Plan covers brush Windstorm Plans in Florida, Mississippi, South Carolina, and Texas offer coverage only against wind and hail damage. Plans in Alabama and North Carolina offer coverage for fire as well. In New York, the Coastal Market Assistance Plan helps homeowners get coverage if their application has been rejected by at least three private insurers.

Hurricanes and Homeowner's Insurance

August 2002 marked the 10th anniversary of Hurricane Andrew, one of the most costly hurricanes in U.S. history. The storm killed 26 people, destroyed 125,000 homes, and caused more than $40 billion in storm damage.

While a hurricane hasn't reached the shores of the United States for two years, the National Hurricane Center cautions people against becoming complacent.

The National Hurricane Center recently predicted that between six and eight hurricanes are expected to form this year. If a hurricane warning is issued, homeowners can board-up their houses and try to minimize the damage. But what if a storm damages their home regardless?

The most common homeowner policy – called a homeowner-3 policy or HO-3 – covers damage caused by a hurricane except for exclusions specifically outlined in the policy. For example, damage caused by hurricane flooding is usually not covered.

For anyone whose home may be damaged by a hurricane, the following tips are offered to help get back on their feet.

Secure the building with temporary repairs – Fix whatever is needed to make the home habitable and prevent further damage. The insured should be careful not to invest in extensive repairs at this time, as an adjuster must appraise the damage first.

The insured should save any receipts so that the insurance company can reimburse them later.

The insured should call their insurance agent to report the loss and get any information they may need from your agent at this time. If the disaster is widespread, the insured should keep in mind that the agent may be remarkably busy.

The insured should save receipts – If temporary living arrangements are needed, they should be sure to save receipts for living expenses, such as food, temporary housing costs, storage, and furniture rentals. Most insurers will advance them the money for these costs.

The insured should make a list of the damaged property. They should include makes, models, and serial numbers. Take pictures of the damaged items, if possible. Organize old bills and receipts, if they are available, to establish value and age.

They should work from memory, if necessary. Don't throw anything away until the adjuster has a chance to inspect and appraise it.

They should identify the structural damage – not forgetting the garage, sheds, and pool.

They should look for cracks and missing shingles or roof tiles. They may want to hire a licensed engineer to identify damage they can't see. Have an electrician inspect the electrical system and a plumber review the plumbing system (most policies cover these inspections).

They should get bids for the repair work.

The insurance agent should arrange for an appraiser to inspect and evaluate. Or the insured can hire a public adjuster for a fee.

If a private adjuster is hired, the insured should ask for a complete inspection and appraisal.

The insured should fill complete the "proof of loss" forms, which will be sent to them by their insurance company. Return them as soon as possible and keep copies of all forms they send back. They should send copies of lists and other documents as needed to prove their losses, making sure to keep the originals.

Tornadoes, Earthquakes, Lightning

Severe weather can pose a major threat to a home and property.

Tornadoes, earthquakes, hurricanes, winter storms, severe thunderstorms, and flooding can damage or destroy a home in a matter of minutes. While weather can't be controlled, one can be prepared.

Specific types of severe weather tend to occur in specific regions at specific times during the year. But it is important to recognize that this is not an absolute.

For example, tornadoes are not restricted to the Plains states-each of the 50 states has experienced at least one tornado in recorded history. Thunderstorms occur throughout the fall and winter months, in addition to the typical summer outbreaks.

It is important to make sure that homeowner insurance is adequate, no matter where an individual lives.

Preparing for the worst if disaster does strike, homeowner insurance is important to help get an individual back on their feet.

Certain events and disasters are not covered under a standard homeowner policy.

Separate insurance must be purchased if property is to be protected against floods or earthquakes.

Generally speaking, homeowner insurance provides three things:

1. Coverage for damage to a home;
2. Coverage for damage to personal property and;
3. Liability protection.

The most common homeowner insurance policy in the United States is known as the HO-3 or homeowner-3 policy. This policy will cover everything except the exclusions outlined in the policy.

Common perils for which an individual will generally be covered under an HO-3 policy include:

* Fire and smoke;
* Lightning;
* Tornadoes and windstorms;
* Hail;
* Explosions;
* Vandalism;
* Theft;
* Damage from vehicles;
* Falling objects;

* Loss of food in the refrigerator or freezer due to power outage outside the home (usually to $500);
* Weight of ice, snow, and sleet (except to fence, pavement, patio, swimming pool, or dock);
* Accidental discharge of water from plumbing system (e.g., pipe bursts) or
* Freezing of plumbing;
* Accidental cracking of the hot water heating system;
* Accidents resulting from insured's negligence on or off their property (includes damages award to third party, medical bills of third party, and legal costs–up to policy limit);
* The insured's personal property anywhere in the world (with some exceptions);
* If it's not in the list of exclusions, it's covered.

What is not covered?

Specifically, the HO-3 policy does not generally cover:

* Floods (flood insurance must be purchased separately from the federal government);
* Earthquakes (can be added to policy);
* War;
* Nuclear accidents;
* Structures used for a business (separate insurance is necessary);
* Wear and tear on the home, including deterioration, insect, and rodent;
* Infestation, settling or cracking of foundation or pavement, and damage from domestic animals;
* Intentional damage;
* Freezing of pipes in an unoccupied or under-construction house;
* Theft from a house under construction;
* Vandalism to a house that has been vacant for more than 30 days;
* Cars, trucks, vans, motorcycles, aircraft, and boats with anything more than a small motor;
* Property belonging to tenants;
* Pets, birds, and fish;
* Losses resulting from the failure to protect property after a loss.

Examples of the above outlined inclusions and exclusions:

* Lighting strikes a power line leading into the house and starts a fire—covered;
* A delivery truck careens off the road and smashes into the house—covered;
* A plane blows up mid-air and part of the debris hits the house—covered;
* A pipe bursts in the cellar and covers the downstairs playroom with water—covered;
* Mice infest the home and chew up the insulation–not covered (wear and tear exception);
* The river behind the house floods and there is water damage to the–not covered (flood exception);
* The home is damaged for some reason and it needs to be upgraded in order to meet the local building codes when it is repaired–coverage depends on the individual policy;
* The value of the home in the real estate market plummets because a water retention plant is built on the next block–not covered (selling cost has no direct relation to insurance, it is intended to cover the costs of rebuilding or repairing);

* A foreign army invades the United States and destroys the home in the process–not covered (war exclusion);
* The insured goes on a cruise for 8 weeks and returns home to discover vandals have smashed all the windows and torn apart the house–not covered (vandalism exclusion for house vacant more than 30 days);
* A wild animal gets into the house and rips apart the upholstery–covered, unless the animal is a rodent or the owner's pet, which is not covered (If the rodent or pet does something to cause a fire, the insured is covered for the damage caused by the fire.)
* A thief breaks into the home while the insured is at work, and steals their entire music collection, the family silver, and everything else portable–covered, up to the limits stated within the policy and any endorsements;
* The golf clubs are stolen from the trunk of the insured's car–covered (without a replacement cost endorsement the insured will recover only their current value);
* A fire damages the computer equipment in the owner's business over the garage–not covered (special coverage is required for a home-based business).

IDENTITY THEFT

Every day more people become victims of identity fraud.

What is Identity Fraud?

Cases of identity fraud are dramatically on the rise. Consumers are usually alerted to identity fraud when a merchant – or their collection agency – contacts the consumer seeking payment for a bill that the consumer knew nothing about.

Worse yet, the consumer is declined for a loan due to a credit report that recorded defaults on loans that were not previously known to the consumer.

In cases of identity fraud, criminals assume the identity of the consumer/victim for the purpose of taking over the victim's accounts and/or obtaining and using credit in the name of the victim, usually with the goal of fraudulently obtaining financial gain.

The occurrence of identity fraud against U.S. consumers has increased in recent years.

In 1998, the credit-reporting agency, Trans Union, received 554,450 calls with questions or complaints about identity theft. Today, the FTC states that 9.9 million people were victims in the last 12 months. That is almost an 18-fold increase between the years of 1998 and 2003.

The Federal Trade Commission further reported that last year's identity theft losses to businesses and financial institutions totaled nearly $48 Billion.

In such cases, banks and other credit grantors, not the consumer, absorbed most of the losses. However:

While generally not responsible for funds that criminals fraudulently obtain, victims of identity fraud are often left with ruined credit histories that can require hundreds of hours and sometimes significant amount of money in expenses to restore their credit standing.

In a study released in September 2003, the Identity Theft Resource Center reported victims spent an average of $1,495 in out-of-pocket expenses and 609 hours to clean up the mess resulting from the identity theft.

In response to this increase in frequency, federal laws passed in 1998 (The Identity Theft and Assumption Deterrence Act of 1998) allow victims to seek restitution from the criminal perpetrator for identifiable losses that include expenses related to clearing their name and credit rating, such as attorney's fees.

In reality, obtaining such restitution from the criminal is far from certain as the victim can be in a long line of parties (e.g., creditors) seeking restitution from a criminal that has committed identity fraud.

How can a consumer reduce their exposure to identity fraud and how can identity fraud be prevented?

A consumer should consider taking these simple precautions to reduce their exposure to identity fraud:

Annually order their credit report from each of the three credit reporting bureaus and review it for accuracy.

Report and question any inaccuracies.

Guard their social security number (SSN). Never put their Social Security Numbers on checks, nor use their Social Security Number or any part of it, as a password at work or anywhere else, and only give it out when they believe it to be of absolute necessity.

Create passwords and PIN numbers that are difficult to guess for all accounts and those Pin numbers should be changed periodically.

Use a shredder to adequately destroy personal financial documents before throwing them out. "Dumpster diving" in trash is a way for criminals to obtain information about a consumer.

Consumers should never give out any confidential information (account numbers, passwords) over the phone to an unsolicited caller who is stating that they represent the consumer's financial institution or similar creditor. This person could be anyone! The consumer should get their name, location and telephone number, and reason that they are calling and call them back at the phone number printed on their billing statements.

The consumer should review all bills and statements closely. Report and challenge any questionable charge regardless of the dollar amount. A small charge could be a first warning sign of a larger problem.

The consumer should go through their wallet or purse, and determine, that if it were lost or stolen, how much information would a thief obtain?

The consumer should not carry their Social Security card, birth certificate or passport with them unless absolutely necessary.

It is wise not to carry extra credit cards and outgoing checks, bill payments or tax documents should not be put in mailbox in front of their home, as they are easy to steal.

All such items should be dropped in a postal service mailbox or directly at the post office.

If a consumer is denied credit or employment, they should find out why. It could be due to errors on their credit report of which they are unaware.

Consumers should be alert to red flags. If they ever receive a call from a merchant, creditor, or collection agency in what seems to be a case of mistaken identity, the consumer should be on alert. The consumer should find out exactly who they are and the details of why they are calling. This may be the first and only warning that the consumer may have, that they are about to become the victim of identity fraud.

In order to provide protection against expenses incurred as a result of the growing hazard of identity theft, insurance companies have introduced Identity Fraud Expense Coverage.

Identity Fraud Expense Coverage Features provides coverage (after a $100 deductible) for these expenses that individuals can incur – at their own expense – in their efforts to restore their financial health and credit history after an identity theft:

* Lost wages as a result of time taken off from work to deal with the identity theft (coverage up to $500 per week for four weeks);
* Notary and certified mailing costs for completing and delivering fraud affidavits;
* Loan re-application fees for re-applying for loans that were declined due to erroneous credit information that had reflected the identity theft;
* Phone charges for calling merchants, financial institutions, and law enforcement agencies to discuss an actual identity theft;
* Attorney fees incurred with the insurer's prior consent, for: defending suits brought incorrectly by merchants and their collection agencies removing criminal or civil judgments wrongly entered against the victim challenging information in a credit report.

The Identity Fraud Expense Coverage endorsement can be added to a consumer's homeowner, condominium, or renters policy and can provide coverage up to $15,000 in protection.

MOLD AND THE INSURANCE INDUSTRY

Concern about the consequences of mold contamination has become one of today's top subjects. The implications of the emerging mold issue for insurance and the economy are serious.

From the insurance perspective, damage from mold, like rust, rot and mildew is specifically excluded in the standard homeowner policy.

Mold contamination is covered under the homeowner policy only if it is the result of a covered peril. For example, the costs of cleaning up mold caused by water from a burst pipe are covered under the policy because water damage from a burst pipe is a covered peril.

But mold caused by water from excessive humidity, leaks, condensation, or flooding is a maintenance issue for the property owner, like termite or mildew prevention, and is not covered by the policy. Most people routinely clean up mold before it grows large enough to become a hazard. Caught early, mold usually can be removed by a thorough cleaning with bleach and water.

While mold has been around for millennia, the number of mold claims submitted to home insurers only increased significantly during the last year. But if insurers are now going to be asked to pay claims for something that is not covered in the policy, the price of home insurance will inevitably rise.

If the longstanding homeowner coverage exclusion for mold is eroded by jury verdicts or judicial interpretations, the basic premises on which the property insurance contract is based will be reversed, and the economic consequences will be severe.

To prevent this, corrective action by regulators and legislators is being considered.

To avoid confusion, many insurers are now inserting clarifying language in their homeowner policies. Some companies may decide to cover all mold claims and price the policy accordingly. Others may exclude mold, but offer an attachment to the policy, called an endorsement, which allows the insured to add the coverage. Still other companies may provide a tighter definition of what is and what is not covered.

While some insurers may prefer to create an absolute exclusion. Most major insurers have announced some form of restriction on writing water damage policies.

Potential rate increases needed to cover the cost of mold claims threaten to make home insurance coverage unaffordable for some and unavailable for others. A crisis in the price and availability of homeowner coverage could have far-reaching effects on home sales and, as a result, the economy as a whole.

As to mold in general, there are more than 100,000 species of mold of which at least 1,000 are common in the United States.

According to the Center for Disease Control (CDC), there is always a little mold everywhere – in the air and on many surfaces. The CDC suggests people should take routine measures to prevent mold growth in the home, usually by stopping the accumulation of moisture.

Homeowner's should be aware that mold should be cleaned up as soon as it appears.

Keep in mind that mold cannot grow without access to moisture. The most effective way to treat mold is to immediately correct underlying water damage and clean the affected area.

The common health concerns from molds include hay fever-like allergic symptoms, the CDC reports. Certain individuals with chronic respiratory disease may experience difficulty breathing. Individuals with immune suppression may be at increased risk for infection from molds. Anyone with these conditions should consult a qualified medical clinician. There are very few case reports that molds containing certain micro-toxins inside homes can cause unique or rare health conditions and a causal link between the mold and these conditions.

THE NEED FOR LITIGATION PROTECTION

If someone is involved in an accident that causes damage to someone else or to someone else's property, or if someone has an accident on the insured's property, the first thing they should do is contact their insurance agent or company. And the agent should take them through the steps of the claim process. Insurance agents should let their clients know that they are duty-bound to report any claim or any potential claim to the company, or to the agent who represents the company.

Some states have ruled that if insurance companies determine a business's liability limits are too low — that is, the amounts of coverage they have are too low for their risks — the insurers are not under obligation to defend the insured if they are sued. This is where the question of the insurance company's legal obligation to the insured gets tricky.

It can't be assumed that the insured can buy the lowest amount of coverage and then get full legal representation. If the suit is settled by the insured, the company will only pay for damages up to the liability coverage.

However, if the case goes to trial, the legal costs and settlement amount will probably exceed the liability limit, and the insured business will have to pay the difference.

Once the agent gets the claim information, he'll pass it along to the insurer's claims department, and the investigation into the situation begins.

It is important to read each insurance policy to see what the insurer will do in the event of a lawsuit.

For example, a sample car insurance policy states: "We will defend any lawsuit brought against the insured [that's you] for" any damages sought by other parties. The policy also states that the insurance company will cover the damages you're liable for up to the limits of the policy. Liability policies for home insurance read much the same way.

In most cases, the insurance company will appoint an attorney for the insured. However, check the policy language, because in some instances the insured may have to supply their own defense.

In addition, if the insured violates the insurance contract, they might themselves be denied a defense from their insurance company, which means they'll have to find their own lawyer and pay out of their own pocket.

An insured may be denied a defense if their conduct is deemed reckless or willfully and wantonly destructive. Insurance companies generally will not defend an individual in cases involving losses caused by their excessive speeding or driving under the influence of controlled substances. These rules are not across-the-board, and each case is judged on its merits.

Every state has different rules, and even some jurisdictions within those states have specific rules.

If the case makes it to the courtroom, expect the process to take at least a couple of weeks, if not more. Look out if you're in New York, though. It can take three years just to get to trial in New York. What's more, case length depends on the particular litigation system, which judge gets the case, and how interested the judge is in moving his docket.

In order to get the best defense, the insured should work with their insurance company. Cooperate with the insurance company's investigation and their defense of the matter.

If the insured isn't cooperative, the insurance company can say they don't have to defend them because they are in violation of their contract.

What's more, litigation can be time-consuming. The No. 1 gripe of policyholders is often the amount of time they are required to spend in court, either to help with the investigation or to testify.

THE TORT SYSTEM AND LIABILITY INSURANCE

Developments in liability insurance are influenced by what is going on in the tort system.

The tort system is the body of law governing negligence and other wrongful acts which result in an injury or damage for which a civil action can be brought, with the exception of breach of contract, which is covered under contract law.

The number of tort filings peaked in 1991, according to data from state courts, although in some states, numbers continue to rise. Meanwhile, the amount of money that may be awarded by juries has increased significantly.

In 1995, awards in excess of $5 million accounted for 2 percent of the total. In 2001, they represented 5 percent, reports Jury Verdict Research, an organization that collects data on personal injury jury verdicts.

The price of liability insurance reflects the costs of the tort system. These include defense costs and claims handling, the amounts paid to claimants and plaintiffs for economic and noneconomic losses, such as pain and suffering, claimants' attorneys' fees, and administrative costs.

LEGAL DEFENSE COSTS

The amount of money insurers have to spend to defend their policyholders against lawsuits directly impacts the cost of insurance. Some liability policies include coverage for unlimited legal defense. In 2001 defense costs as a percentage of losses incurred increased in terms of the dollar amount spent but decreased as a percentage of losses.

This decrease was particularly noticeable in workers compensation, the largest of all commercial line segments where ideally, because it is based on a no-fault system, defense costs should be minimal. Defense costs increased substantially in product liability, where litigation is complex, trials tend to last longer and require more documentary evidence, and more expert witnesses are used.

Despite the large amounts spent however, in many cases defense costs more than pay for themselves by reducing judgments against policyholders. Lawsuits represent only a fraction of total liability claims. About 2 percent of such claims are settled by verdict and only about one third of claims become lawsuits. But lawsuit verdicts are important because they influence the damage amount plaintiffs seek and the size of out-of-court settlements.

COST OF CLAIMS AND LIABILITY LIMITS

Litigations are not only driving up the cost of insurance but also the amount of insurance that businesses must buy to protect themselves against lawsuits, potentially driving up the price of goods and services for all consumers.

A study of liability policy limits of some 2,600 companies in the United States by Marsh Inc., a large insurance brokerage firm, found that 8.6 percent of firms had suffered a loss of $5 million or more in the first quarter of 2002, a somewhat lower proportion than the 9.3 percent in 2001. Those that experienced such a loss tended to purchase much higher limits of liability coverage.

MEDICAL MALPRACTICE

BY 2001, medical malpractice premiums barely kept pace with medical care inflation and the expansion of the medical care industry in response to population growth. Meanwhile, losses continued to soar as the median award reached $1 million, the average award grew to $3.9 million and the high end of the award range, which fluctuates, exceeded $131 million for the first time.

In 2001, the latest data available, insurers paid out more than $1.53 for every dollar they collected in premium.

GENERAL LIABILITY INSURANCE

This line of insurance covers the liability risks of a business arising from injuries or property damage that is caused by its products, completed jobs, premises and operations, elevators, and independent contractors.

PRODUCTS LIABILITY

Despite a large increase in the volume of premiums written, products liability insurers still paid out more than twice the amount they collected in premiums.

Products liability awards begin to escalate in 1998. The median award has more than tripled from 1995 to 2001 and the cost of defending product liability lawsuits has also soared.

ASBESTOS LIABILITY

More than 600,000 workers have filed asbestos claims, many against multiple defendants; more than 8,000 companies have been named as defendants; some 60 companies have become bankrupt because of these liability claims; and as many as 60,000 people have lost their jobs as a result of closings and layoffs as the economic repercussions ripple through local economies. Most of the people who are filing claims are not yet ill, according to a RAND study, and may never become impaired but are filing claims now out of fear that they may become ill in the future. Meanwhile, as defendants' funds are depleted by the onslaught of claims, seriously impaired claimants are receiving a fraction of the compensation to which they are entitled.

Researchers estimate that asbestos liability could ultimately cost U.S. insurance companies as much as $65 billion.

DIRECTORS AND OFFICERS LIABILITY INSURANCE

Directors and officers liability insurance (D&O) covers directors and officers of a company for negligent acts or missions and for misleading statements that result in suits against the company. D&O policies usually contain two coverages:

* Personal coverage for individual directors and officers who are not indemnified by the corporation for their legal expenses or judgments against them — some are not required by their corporate or state charters to provide indemnification; and corporate reimbursement coverage;

* For employment practices liability (EPL). EPL coverage may also be purchased as a stand-alone policy.

A 2001 D&O survey of more than 2,000 U.S. and Canadian corporations by Tillinghast-Towers Perrin found that 19 percent of U.S. participants reported one or more D&O claims within the last 10 years. Among U.S. for-profit companies, nearly one-third of all claims were filed as class actions, which can be costly to defend and often result in large payments.

SECURITIES LITIGATION

A company's directors and officers liability insurance may cover damages awarded in class action lawsuits claiming that investors lost money due to the company's negligent actions or omissions.

According to a study of securities class action filings filed by Stanford Law School Securities Action Clearinghouse in cooperation with Cornerstone Research, the most frequent allegations (more than 80 percent) are that the company failed to disclose material information or misrepresented financial data.

In 2001 and 2002, there were a number of class action suits that were atypical of traditional securities class action filings. These fell into two groups: "laddering" cases involving initial public offerings and analyst cases. Laddering cases are those in which some IPO customers allegedly agreed to purchase additional shares at progressively higher prices.

Analyst cases allege research reports and ratings were not independent or objective.

Not counting these two atypical types of actions, securities class action filings in 2002 rose 31 percent in 2002 the second highest of any year since the passage of the Private Securities Litigation Reform Act, enacted in December 1995, to reduce the number of shareholder lawsuits.

The companies sued lost more than $1.9 trillion in market capitalization, a 24 percent increase over the figure for companies sued in 2001, a Stanford Law School and Cornerstone Research study reports.

Securities class action lawsuits have not only increased in number but also in settlement value. In a study of 400 securities cases filed after December 22, 1995, for which settlements were reported through year-end 2002, Cornerstone Research found that the median settlement value rose by 20 percent in 2002 compared with the value for all settlements in the post-reform years, 1996-2001. Three hundred and two cases were settled in 1996-2001 and the remaining 98 in 2002.

The rise in settlement values is due in part to the increase in mega settlements, a trend that is affecting many kinds of awards. Mega settlements help push up the cost of insurance because they contribute to uncertainty about future award patterns. Rates are set based on what past claim trends tell about the future. Since securities cases tend to be settled more than two years after they are filed, Cornerstone suggests that the impact of the stock market environment in 2000 and 2001 may continue to be felt in future years.

URBAN INSURANCE ISSUES:

UNDERWRITING, THE TASK OF DECIDING WHAT RISKS TO INSURE

Differences in prices for insurance must reflect expected differences in losses and expenses. When the risk of future losses increases or when rates are inadequate, insurers become more selective about the degree of risk they will assume in an effort to preserve their profit margin.

However, redlining, defined as refusal to issue or renew, or to cancel an insurance policy based on the geographic location of the structure or individual to be insured, is illegal in every state.

Because losses tend to be higher in urban areas, rates for auto and home insurance are often higher than average in inner cities. This has raised questions about the availability and affordability of insurance in urban communities.

Responding to these concerns, the insurance industry is redoubling its efforts to enhance the insurability of inner city properties and to push for changes in auto insurance that would enable drivers to have more coverage options. In addition, the nation's leading home insurers have changed their underwriting guidelines on older houses. Insurers are also collaborating with community development organizations, such as Neighborhood Housing Services, to help residents improve their homes and their community environment, and they are taking steps to expand marketing activities in urban neighborhoods.

An analysis of homeowner insurance claims in eight major cities and the communities within five miles of those cities' boundaries found that homeowner insurance claims were more frequent in the cities than neighboring communities and that they were also more expensive.

The study's findings confirm what other research has shown that the cost of homeowner insurance in cities is higher than average due to higher than average loss costs.

New Jersey: In January 2003, New Jersey Gov. James McGreevey proposed a dollar-a-day auto insurance plan to make coverage more affordable for the state's low-income drivers. The plan was incorporated into the regulatory reform bill passed by the legislature a few months later in May.

The special automobile insurance policy pays up to $15,000 of most medical expenses after an accident and $10,000 in death benefits and, like the standard auto insurance policy provides coverage for catastrophic injuries such as severe brain damage up to $250,000. The program, which is administered by the Personal Automobile Insurance Plan, the state's assigned risk program, covers relatives as well as the driver. Eligibility is based on standards for Medicaid.

In addition, the governor created a task force on urban insurance, focusing primarily on the cost and availability of auto insurance and reducing fraud. The role of the task force is to gather information the department has not previously gathered to help guide discussions about how to address specific urban needs such as attracting more insurance agents.

A quota system set up under the state's Urban Enterprise Zone program to boost the number of insured drivers in the inner cities has been successful, according to state officials. The law had been scheduled to sunset this year but was extended to 2006. In the first two years, the state Department of Banking and Insurance reported a 12 percent jump in the number of vehicles insured in the state's urban areas over the two-year period compared with a 4 percent growth rate over the same period elsewhere in the state. The 1997 law that created the program requires insurers doing business in the state to have the same market share in cities as in suburban and rural areas.

While the program has been effective in expanding the inner city auto insurance market, this has come at a cost to other drivers in the state, insurers note. Under a 1983 law that caps urban auto insurance rates at 135 percent of a company's statewide rate, rural and suburban drivers are subsidizing urban drivers. According to the Insurance Council of New Jersey, the number and cost of claims in the state's inner cities is three times the cost elsewhere in the state.

Previous reform measures passed in 1998 were intended to eliminate to the greatest extent possible the subsidies urban drivers receive. The Assembly had wanted to eliminate the subsidy immediately but the Republican leadership had promised to reduce auto insurance rates for good drivers regardless of where they live. Under a compromise, the cap was to be rescinded sometime before the year 2000. But the question of subsidies is part of the larger subject of rating territories. This was to be addressed by a committee, as dictated by the law, but because of initial delays in naming people to the committee and the fact that it has met infrequently since its formation, there is as yet no new territory map and so the cap has not been removed.

The committee, which is composed of actuaries, insurance executives and public officials, is charged with redrawing rating territories, the geographic areas which dictate the rates that people living within that area will pay. The law says that new rate differentials between one territory and another cannot be substantially different from those that exist today. The committee is required to submit its recommendations to the Insurance Commissioner who has the power, under the law, to make changes.

The 1998 reform law also included a basic low-cost policy that offers $15,000 personal injury protection (PIP) and $5,000 property liability coverage and optional $10,000 liability coverage for bodily injury. Catastrophic injuries are covered under PIP up to $250,000. After a slow start, more drivers purchased the basic policy in 2001. There are now about 35,000 basic policies in force.

California: In May 2003, the cities of Los Angeles, San Francisco, and Oakland along with several consumer groups petitioned the state's insurance commissioner, to lower auto insurance rates in inner cities, saying that Proposition 103, a law passed by the voters in 1988, had never been properly enforced. One provision of Proposition 103 was that prices for auto insurance should be based more on individual safety records than on zip codes. But the law was written ambiguously, observers say, allowing zip codes to be one of several other rating factors allowed.

A similar lawsuit was filed by a coalition of consumer and minority groups and the three cities against a former commissioner, Chuck Quackenbush. After years of litigation over whether geographical areas or "territories" should be used to help set rates and what weight they should be given in the rating process, a state appeals court hearing the coalition's initial suit characterized the voter initiative as contradictory, saying that the law requires the insurance commissioner to protect consumers from arbitrary rates but at the same time requires rates to be based on a driver's driving history. Safety record, miles driven and driving experience are not as important in assessing potential losses, the court said, as where the driver lives.

In 1999, legislation was introduced in the California legislature to address the problem of uninsured motorists in the state by creating a low-cost auto insurance program. The premise was that drivers go without liability insurance because of the cost and that if it were affordable, more would buy it.

The number of drivers obtaining coverage under the state's low-cost program, which operates only in Los Angeles County where about 40 percent of the state's uninsured drivers live, and in San Francisco, has been far below expectations with fewer than 2,200 policies in force in the first two years. By the end of 2002, there were 4,000 policies.

In January 2003, eligibility requirements and the basic price of the policy were changed in the expectation that more people would qualify for and therefore buy the coverage.

It's difficult to judge the program's success because it has not been in effect long enough for the insurance industry to collect data on it.

The pilot program now provides a low-cost policy to anyone whose annual income is no more than 250 percent of the federal poverty level, roughly $38,000 for a family of three, and who also meets the criteria included in the enabling legislation.

The policy is available to good drivers at the flat rate of $347 in Los Angeles and $314 in San Francisco. A good driver is defined as one that has no more than one traffic violation and one at-fault accident in the prior three years. However, because as a group young men between the ages of 19 and 24 are generally the most expensive to insure — they are involved in more serious, hence more costly, accidents — young men may be charged 25 percent more. Drivers younger than 19 are not eligible to buy the policy.

Liability coverage, at $10,000 for bodily injury to an individual, $20,000 for injuries to more than one person and $3,000 for property damage, is lower than the state's minimum liability limits but since 90 percent of bodily injury claims are for less than $10,000, according to insurance industry data, the policy is expected to cover most claims.

The pilot program, which is run by the state's assigned risk plan, began operations in July 2000. Initially the enabling legislation was for two years, the program now sunsets in 2007.

Originally there was great interest in the program but only a small proportion of drivers in the two cities meet the qualifications. Among those who do, however, experience so far suggests that for many drivers with incomes close to the poverty line, the cost of insurance is still too high to enable them to comply with the state's compulsory auto insurance law.

And for those who qualify but have bought insurance through the regular market or the assigned risk plan, the cost of the bare-bones package, which offers no first-party (policyholder) medical care, is not so low that drivers with a policy providing broader coverage are likely to switch.

The low-cost plan came about as a result of discussions about extending the state's mandatory automobile insurance law. Some lawmakers said that enforcement of the mandatory law should be contingent on the existence of a low-cost policy for low-income drivers. The bill extending the mandatory auto insurance law was amended so that it would not become law unless such an auto insurance policy was developed.

In Philadelphia, one of the first actions of the newly created Office of Consumer Affairs was to file a formal complaint with the state's insurance commissioner arguing that city residents were the victims of practices that pushed up auto insurance rates and demanding a rate rollback of between 15 and 25 percent.

Property Insurance

FAIR Plans in the majority of states continue to shrink both in terms of the number of policies written and total premium, reflecting insurers' growing interest in urban markets, despite the higher incidence of losses in such areas.

The plans were set up to make insurance available in inner cities after the urban riots in the 1960s. Some FAIR plans have also become the insurer of last resort for people in certain areas outside central cities, such as the coastal counties of New York State and Louisiana.

For the past several years, many insurers, alone and in conjunction with low-income housing groups, have been funding and promoting programs that help homeowners recognize and correct hazardous conditions in and around their homes that can lead to injuries and property damage. Experience with such programs has shown they are effective in reducing both the number and seriousness of homeowner claims.

The National Insurance Task Force, part of the Neighborhood Reinvestment Corporation, has developed similar programs to address the underlying causes of loss in lower-income neighborhoods in certain cities.

These loss prevention programs, known as Loss Prevention Partnerships, are aimed at reducing specific hazards that have been identified as the most serious causes of loss in five targeted urban communities. Insurers are providing much of the funding.

The communities are Chicago and St. Louis where fire is a particular problem, Denver, and Richmond where the problem is theft and Staten Island, New York where water damage is prevalent.

The Neighborhood Reinvestment Corporation is a congressionally sponsored not-for-profit organization designed to revitalize urban neighborhoods across the country.

The loss prevention programs have already reached many homeowners, especially where marketing efforts have been strong. By the end of 2002, the program had educated 2,280 people through home safety seminars, conducted 839 home safety inspections, and made 314 loans and grants totaling $1.66 million.

Surveys show that 89 percent of seminar graduates have taken steps to improve the overall safety of their homes and most plan to take additional measures. In addition, the programs through their emphasis on improving communities have opened up new opportunities for insurers who previously may not have viewed economically risky neighborhoods as good markets.

Investment in Urban Communities: In 1998, a group of insurers doing business in California created an investment vehicle, Impact Community Capital, to increase the industry's financial support for low-income communities.

In the period of time that it has been in existence, Impact has pioneered the securitization of mortgages for community housing.

Securitization enables capital to be recycled into new affordable housing. In the securitization process, mortgages and other loans are pooled and sold as securities, which immediately puts money back into the hands of the banks and other lenders to make more loans.

As an example, early in 2002, Impact purchased $124 million in community development mortgages from Bank of America on behalf of its insurance company members. The portfolio contained 7,108 units of affordable housing in 95 separate properties, including housing for families, senior citizens and the developmentally disabled.

In 2003, Impact and Bank of America formed an alliance that resulted in the construction of nearly 15,000 new affordable housing units throughout the United States over the following three years.

The Community Impact Loan program is the first-of-its-kind collaboration between the largest originator of community development loans in the United States and top national insurance companies.

Insurers fund Impact and also invest in its mortgaged-backed securities. Members of Impact, now 10 companies, represent 25 percent of the California property/casualty and life insurance market.

The Impact transactions were approved by the California Organized Investment Network (COIN), which facilitates insurance industry investment in low-income urban and rural communities. COIN is a collaborative effort between the California Department of Insurance, the insurance industry and community groups.

A LITTLE BACKGROUND

Insurance availability and affordability in urban areas is a multifaceted problem with no easy solutions. On the property side, increasingly the issue is not so much availability as affordability.

In some parts of the country, people who live in central cities may have fewer difficulties finding insurance than rural property owners who may suffer from the same income limitations with the additional problem of inadequate fire protection.

On the auto insurance side, in several states with large urban areas, pilot programs that offer lower priced coverage have been created. In the past, there was hope that no-fault auto insurance would help solve the problem by putting more of the insurance premium in the hands of accident victims but no-fault systems have encouraged fraud in some inner cities pushing up the cost of coverage in the very areas where people can least afford it.

Property Insurance

Community activists have charged that homeowner insurance is difficult to obtain in inner city communities, that it is more expensive, and that urban applicants are offered fewer comprehensive policies than people living elsewhere.

Studies by many different groups have shown that residents in urban communities have insurance (banks generally will not issue a mortgage without proof of insurance) and that the rates charged are in line with losses. However, because of the higher risk of loss (fire, vandalism, and theft) more inner city homeowners are often insured outside the regular market just like people who live in coastal areas exposed to hurricanes.

A study of homeowner claims in eight major cities and the communities within five miles of the cities' boundaries found a different pattern of claims in each city. The eight urban areas studied were Chicago, Detroit, Los Angeles, Milwaukee, New York City, New Orleans, Philadelphia, and St. Louis.

The study, conducted by the Insurance Research Council, found that theft accounted for the greatest number of 'claims in five cities and water damage in two, but in St. Louis there was no predominant cause. In three cities, the greatest dollar losses were due to fires but in New York liability claims accounted for the highest dollar amount and in Philadelphia it was water damage.

The study also found that there were more claims than the national average in the cities and their neighboring communities — a claim frequency of 115 per 1,000 insured homes compared with 100 nationally — and that homeowner insurance losses were 18 percent more frequent in the cities than in the adjacent areas (124 claims compared with 105).

In addition, the average amount paid (claim severity) was 20 percent higher in the cities than in the ring communities with average claims at $3,155 in the cities and $2,619 in the outer areas.

Together, the higher claim frequency and severity in the cities raised loss costs by 42 percent for city policyholders over their ring area counterparts ($392 vs. $275). Loss costs are the insurer's cost of "goods" before any sales or administrative expenses, tax or profit margin have been added in.

The prevalence of older homes in central cities has also led consumer groups to charge that urban homeowners were unfairly discriminated against. Older homes present a problem in that the decorative and uniquely crafted features can push repair or replacement costs significantly above a home's market value and raise premiums to the point where insurance could become unaffordable.

Many insurers therefore will not offer owners of older homes a full replacement cost policy, the most comprehensive homeowner policy that pays to rebuild the structure as it currently exists, regardless of whether they live in an expensive Victorian mansion in suburbia or a more modest home in the inner city. Instead of a full replacement cost policy, owners of older homes may purchase a policy based on the fair market value of the home with rebuilding costs based on standard building materials and techniques.

However, in response to the perception that homeowner insurance is not available in inner cities, some major insurers are changing their business practices regarding older homes, including eliminating age restrictions and minimum market value.

Instead, they will inspect the heating, plumbing and electrical systems and roofs more rigorously for hazards that could lead to losses and suggest repairs or replacement where necessary.

After the urban riots in the mid-1960s, insurers were reluctant to write policies in inner city areas because of the devastating losses they sustained. To improve economic conditions in these communities, Congress passed the Housing and Urban Development Act in 1968.

This made federal riot reinsurance available to states that set up FAIR Plans (Fair Access to Insurance Requirements), property insurance pooling mechanisms that made basic property insurance coverages available to homeowners living in urban areas where it was difficult to obtain insurance. Insurers needed federal riot reinsurance to protect them from fire and vandalism losses should riots erupt again. The private reinsurance market soon replaced the federal program but FAIR Plans and other residual market programs still exist to provide insurance where the voluntary market will not, see report on the residual markets.

The availability of insurance again became an issue in the aftermath of the Los Angeles riots in 1992. Some small businesses located in the areas destroyed by fire and looting failed to reopen, in part because they lacked the proper business insurance coverages.

At the same time, community activists began to accuse the insurance industry of deliberately discriminating against inner city neighborhoods.

As proof of redlining, they cited the difficulty of obtaining insurance in urban communities where the housing stock is often old and the fact that owners of older homes were offered policies that provided “actual cash value” — the depreciated value of damaged items — rather than replacement cost coverage.

Surveys by independent research groups for the insurance industry showed that most homeowners (98 percent) living in major cities had home insurance and only 3 percent of those surveyed said that they were aware of anyone in their neighborhood having difficulty obtaining homeowner insurance.

Nevertheless, the charges of redlining prompted regulators and lawmakers to consider imposing expensive data collection requirements on insurers to monitor property insurance sales, marketing, and cancellations.

While data collection proposals failed to muster support in Congress, a program designed to encourage increased competition among large insurers in “underserved communities” is in place in California.

Insurers with a significant presence in the state’s urban markets or a plan to bolster inner city business are exempt from data collection requirements.

By laws or regulation, redlining is illegal in every state and there is no evidence to suggest that insurers unfairly discriminate based on racial or ethnic differences. However, insurers do discriminate based on risk and a company’s profitability is determined in large part by its ability to evaluate risk and charge a premium commensurate with the potential for loss.

To help underwriters distinguish between what the company considers good and bad risks within the confines of its marketing strategy, insurers develop underwriting guidelines.

These guidelines provide a framework for underwriting decisions by identifying what factors should be considered in accepting applications for coverage. They also help ensure underwriters’ selection decisions are uniform and consistent throughout the company.

For example, an insurer that wants to limit its exposure to hurricane damage may decide to decline all applications for property insurance on buildings within a certain distance from the ocean. Surrogates for distance such as zip codes or counties may measure in yards or that distance. In regions prone to hailstorms or brush fires, insurers may refuse to insure homes with certain types of roofs.

Until recently, many insurers also based underwriting decisions on the age of a home and its market value. Many older homes have features that are expensive to replace which can push the cost of rebuilding these structures higher than their current market value. To control premium costs for the homeowner who may not be able to afford or desire to replace decorative molding, stained glass windows and other expensive features, some insurers restrict full replacement cost coverage to homes built before a certain date.

Other insurers now give policyholders the option of whether to purchase replacement cost coverage at its higher price. However, insurers may still refuse to insure homes where the heating, plumbing and electrical systems have not been modernized to reduce potential fire and water damage claims or where the roof is in poor condition.

The insurance industry has been working with community groups, such as the Neighborhood Housing Services, in New York, St. Louis, Philadelphia, Seattle and other major cities across the nation to increase understanding of insurance, make homes more insurable and help insurance companies better market products and services in these communities.

These relationships are leading to the development of new insurance products or the modification of existing policies to better meet the insurance requirements of central city consumers and greater awareness among potential applicants of how to reduce losses.

In addition, outreach programs have been established to increase the number of insurance agents in predominately low-income areas and to make it easier for them to be financially successful. In some states, Market Assistance Programs (MAPs) have been put up to help insurance buyers and agents find insurance.

Texas, for example, adopted new rules in 1997 that bar the use of age and value as the sole criteria for declining to insure a home and put into effect two programs to address urban (and rural) markets. One is a traditional market assistance program. The second offers financial incentives for insurers to offer a basic residential insurance property policy.

Insurers doing business in California must file community service statements. These anti-redlining regulations, which were originally adopted by former Insurance Commissioner John Garamendi, require insurers to submit detailed information on business activity in all zip codes in the state, including the race and national origin of applicants for insurance. Insurers that present plans and goals to service “underserved communities” are exempted from the data reporting rules. The commissioner reviews these plans. Companies that fail to submit acceptable proposals are subject to the existing data reporting regulations.

In Massachusetts, insurers receive credit against Massachusetts FAIR Plan assessments for voluntary market policies written in certain areas of the city. In addition, the state’s 25 largest insurers are required to disclose their record of homeowner policy sales in these neighborhoods. Insurers are now allowed to write policies that cover the fair market value of properties rather than their replacement cost. (Formerly, insurers were required to provide replacement cost coverage, which, on a large, older house with a low market value, made the cost of insurance prohibitive.)

Auto Rates In Central Cities

Auto insurance rates are generally higher in central cities.

There are several reasons for this including the greater traffic density and pre-automobile-era design of streets in the older cities of the Northeast that increase the risk of accidents and the higher incidence of theft and vandalism.

In low-income urban communities, where the cost of insurance may force drivers to choose between insuring their vehicle and purchasing other basic necessities, many cars are uninsured. Insurers have long advocated auto insurance policies that provide basic insurance coverage as a cheaper option for low-income drivers who have less need for liability insurance because they have no assets to protect if they are sued.

In some states with large urban populations, regulators have placed restrictions on auto insurance rates for central city drivers. These caps force non-urban residents to pay a subsidy to keep urban insurance prices more affordable, the reasoning being that the influx into central cities of drivers who work and shop there but live elsewhere is responsible in part for the greater number of traffic accidents. However, where one by data on losses, the insurance market tends to contract, causing availability problems and pushing more drivers into pools, insurers of last resort such as assigned risk plans.

Linked to this is the concept of rating by geographic area or territory. Consumer activists claim that auto insurance rates would be fairer to urban drivers if they were based primarily on a driver's own driving record, the miles the policyholder drives each year and driving experience.

But, because the number and severity of accidents may differ from one locality to another, where a person lives is an important predictive factor in calculating accurate rates. Rating systems that restrict the use of territory as a major factor in setting premiums create a cross-subsidy that tends to favor people who live in urban areas with high traffic density and higher than average theft rates at the expense of suburban and rural drivers.

Over the past decade, insurers and lawmakers have tried to enact no-fault auto insurance programs of various kinds, in an effort to lower premiums. But, with the exception of Pennsylvania where a choice no-fault system has offered urban drivers a means of reducing the price they pay for auto insurance, efforts to introduce no-fault have been unsuccessful, largely due to opposition among trial lawyers and others whose income would be reduced if more claims were settled outside the court system. In addition, the high incidence of fraudulent personal injury protection claims in some urban areas of states with no-fault auto insurance laws has led to calls to dismantle some no-fault systems.

CREDIT HISTORY AND AUTO INSURANCE

Over the last few years, many insurance companies have started credit information to help determine what a customer pays for an insurance policy. In fact, over 90% of insurance companies use insurance scores, according to a study by Conning Research and Consulting Inc., a Hartford, Conn.-based research firm.

To help you better understand how a credit-based insurance score is calculated and how that "score" impacts what a consumer pays for a policy, we have developed the following list of frequently asked questions. Please note that the use of insurance scores varies by state.

What is an insurance score?

An insurance score is determined by reviewing a consumer's credit history. A carefully developed and tested computer model performs this analysis, and looks at information such as payment history, whether an individual has filed for bankruptcy, if they have bills with a collection agent, any outstanding debts they may have, and the length of their credit history.

Unlike a "credit score," which is typically used when an individual is seeking a loan, an insurance score is used to help insurance companies accurately assign the best price available for an insurance policy.

When calculating the insurance rate, insurers typically group consumers into categories.

For example, driving record and age are the most often used categories to help calculate the cost of a customer's auto insurance policy.

Insurance scores are just another method insurance companies use to determine what an individual pays for their insurance policy.

According to extensive industry and independent research, people with certain patterns in their credit history that result in a lower insurance score are more likely to have claims that need to be paid by their insurer.

For instance, keeping credit card balances below the maximum limit and making regular, on-time payments will result in a higher score. On the other hand, if an individual has a history of "maxing-out" their credit cards to their limits and submitting late, the score will be negatively impacted, meaning a lower score.

An insurance score DOES NOT take into account income, race, gender, religion, marital status, national origin, or geographic location. It only reviews credit history.

Why insurance scores?

Since insurance scores have been proven to be highly predictive of the potential for future losses, they help insurance companies determine the likelihood that a customer will file a claim, and thus allow carriers to set rates that are accurate and appropriate for each customer.

This enables carriers to offer insurance coverage to a broader range of customers. What's more, many of these customers benefit from the use of insurance scores in the form of lower prices.

Insurance scores are used in the same way as other traditional underwriting factors. For instance, younger drivers usually pay more for insurance than older, more experienced drivers do. That is because the less experienced drivers tend to have more claims than older drivers. Of course, this does not mean that all drivers under the age of 20 are poor drivers. Most young drivers, however, pay a higher premium that reflects the higher risk they represent to an insurance company. Since older drivers pose a lower risk of loss, they are charged less.

The same applies to insurance scores. As a group, people with certain patterns in their credit history receive lower insurance scores and are more likely to experience a loss and file a claim. They are charged a higher premium to reflect that risk. This allows insurers, to give better rates to consumers with higher insurance scores, who are less likely to file a claim.

Credit history helps predict the potential for future losses, but it is not the sole factor in determining the cost of a policy. It is one of several factors used to arrive at the best rate possible. The age of a driver and prior claim history are two other important factors that are also used to determine your rate.

Information affecting insurance scores:
In determining an insurance score, the following information is used:

- Payment history (Does an individual generally pay their bills on time or are they more than 60 days late?);
- Bankruptcy, foreclosures, and collection activity;
- Length of credit history;
- Amount of outstanding debt in relation to credit limits (Is an individual "maxed-out" or are they well within their limits?);
- Types of credit in use (e.g., mortgages, installment loans);
- New applications for credit requested.

Isolated problems on credit reports

Insurers recognize that sometimes people face difficult circumstances, such as medical collections, divorce, or job loss.

In most cases, an isolated instance of a late payment will not have a significant impact on an individual's insurance score if their otherwise is an established pattern of responsible credit use.

Insurers use insurance scores together with a number of other factors (including the factors mentioned above) to determine the best pricing level available to an individual. Generally speaking, customers who have higher insurance scores and no prior claims or accidents qualify for the best price. For those customers with prior claims or accidents, a higher insurance score will help them qualify for a better rate than a similar customer who has a significantly lower insurance score.

In turn, customers with no prior accidents or claims, but who have low insurance scores, may also qualify for a competitive rate.

Numerous federal and state laws and regulations are in place to protect an individual from credit score abuse. Under federal law, if the information in an individual's credit history results in an "adverse action," by a company, that company must notify the individual and inform them about how to obtain a free copy of their credit report.

The individual is also provided with a description and of their right to dispute the accuracy or completeness of their credit history.

Improving the insurance score?

One of best things an individual can do is to make sure they pay their bills on time. That will help little by little with their credit history.

An individual can also review how much credit they have.

Are they up to their limit on a credit card? If so, that may be considered an unfavorable factor. One should consider how to reduce their debt without creating additional credit activity. Also, an individual should review their credit report regularly. Resources such as the American Insurance Association (www.aia.org) provide additional information about how to improve a credit history.

Information about insurance scores

The Insurance Information Institute website (www.iii.org) contains a great deal of specific information on this topic under the "Credit Scoring" link. It also contains links to other helpful resources.

Controversy Over Credit Scoring Pricing Policies

Consumer watchdog groups are lashing out at insurance companies for using an individual's credit history as part of policy pricing considerations. Among the credit scoring critics is former Texas Insurance Commissioner Bob Hunter.

Says Hunter: "Explain to me this — if I'm laid off because of September 11 events, and I get behind on my bills for a few months — why should I be considered a worse driver and have to pay more than if I were employed."

Hunter also expressed concern that statistics used in insurance company rating data could become skewed and offered the following example: "Part of the equation is a driver's location.

Credit scoring companies don't share their data, so the info cannot be analyzed independently."

"Further, the use of credit scores may disproportionately against poor and minority consumers, who have little or no credit history, by placing them in higher rating and requiring them to pay higher rates," added Hunter.

"If I could get that data, I could determine whether or not low income and minority consumers are unfairly discriminated against. Many companies often forced these same consumers to pay their entire premium in one payment, since their credit scores do not allow them to qualify for installment payments."

Texas consumer advocate Birny Birnbaum said "it's inherently unfair, because it punishes people who are already victims of economic, medical or personal catastrophes." For example, Birnbaum went on, "the main reason why people experience bankruptcy is because they lost their job, lost health insurance or were divorced."

Like Hunter, Birnbaum ties in the 9/11 tragedy to his credit scoring comments. "Look at all the people who got laid off in the aftermath, Sept. 11, particularly in the travel-related industry. A lot of those people had an increased use of credit to pay bills to compensate for lost income. Why should homeowners and motorists end up paying extra because of economic fallout from the terrorist attacks on America?" Birnbaum is the Executive Director of the Center for Economic Justice, a consumer watchdog group based in Austin.

Birnbaum points out that credit scoring provides no economic incentive for loss prevention by a consumer. "Instead, all credit scoring does is shift premium from one group of consumers to another. Contrast that with, for example, a discount given for installing an anti-theft device in your home or car. With the antitheft discount, the reduced premium for some consumers is paid for through lower claim costs, not by charging other consumers more money as you have with credit scoring."

Lamont Boyd works for Fair, Isaac, an analytic software company headquartered in San Rafael, CA, and works out of their Scottsdale, AZ office as an Insurance Market Manager. He defends insurance company use of credit scoring. Credit-based insurance scoring is a "viable tool for determining the insurance loss potential of an insurance company customer," said Boyd.

Boyd noted "the number of insurers using this tool has grown significantly since 1991 when our company introduced the tool to the business world." "Fair, Isaac has about 350 U.S. and Canadian property-casualty insurers clients that use Fair, Isaac products to underwrite and price automobile and homeowner insurance," said Boyd.

"And the use of credit-based insurance scoring has more than doubled in the last five years and that's despite critic concerns about use of that technology," said Boyd. Boyd scoffs at critics' contention that consumers pay more for insurance when credit scoring is part of the pricing equation. "That's simply not true," said Boyd. "Matter of fact, most insurance company customers pay less than they would if that technology wasn't being used in policy pricing. The reason is, most people manage their credit very well, and they benefit as a result."

INDUSTRY FINANCIALS AND OUTLOOK

Rising construction costs and increasingly expensive natural disasters pushed the cost of homeowner insurance up by 8 percent in 2004, according to a report by the Insurance Information Institute (I.I.I.)

"Part of the increase reflects choices more homeowners are making," said Robert Hartwig, senior vice president and economist for the I.I.I. "People are taking advantage of record low interest rates and are moving into new homes or making additions to their existing homes in near-record numbers," he said. "These upgrades and additions are pushing up insurance costs. People expect their premium to stay the same, but they don't realize they have more house to insure."

According to the I.I.I., between 1990 and 2002, home insurers paid out, on average, $1.17 in losses and expenses for every $1 they earned in premiums. In 2002 alone, home insurers paid out $3.5 billion more in losses and expenses than they received in premiums. In 2001, home insurers lost $7.3 billion, the second worst year on record (the highest is 1992, which included Hurricane Andrew, produced losses of $11.5 billion).

Losses in the homeowner insurance line over the four years since the turn of the century (2000 through 2003) are estimated at $17 billion, approaching the level of insured property losses from the September 11 terrorist attack.

Approximately 41 million homeowners have added to or improved their homes between 2001 and 2002. In 1999, the most recent year for which annual figures were available, an estimated $25 billion was spent on home improvements.

During the 1990s, the severity of catastrophes began to increase dramatically. Between 1990 and 2003, insurers paid out more than $100 billion in catastrophe-related losses – or about $700 million per month.

Catastrophes include well-known ones such as Hurricane Andrew and the Northridge earthquake, but also hundreds of smaller disasters associated with tropical storms, tornados, wildfires, hail, ice, and snow.

"Homeowner's insurance rates in many parts of the country continue to rise because of the extraordinary costs associated with paying these claims," said Hartwig. "In fact, virtually every part of the country is either at risk of or has experienced a billion-dollar disaster."

Mold in homes is not new. However, increased public anxiety stemming from publicity surrounding high-profile lawsuits in Texas and California has increased the risk associated with water damage across the country.

"There is no new 'killer mold' out there," said Hartwig. "But the sharp rise in mold claims is definitely a 21st-century phenomenon. Unfortunately, so are multi-million-dollar jury verdicts. The virtual collapse of the insurance market in Texas can happen anywhere else, so steps are being taken to limit coverage and contain mold costs. But we are still in a situation where a water damage claim anywhere in the country can produce a million-dollar lawsuit. Insurers have to factor that into the cost of insurance."

In Texas, for example, mold was not a market factor until 2001, when claims shot up to $1 billion. In 2002, mold costs surged to $2.3 billion, according to figures from the Texas Department of Insurance.

Factors Affecting Homeowner's Insurance Premiums

While the typical American homeowner paid $536 in 2001 and $668 in 2003, rates do vary significantly from one part of the country to another. The housing market crash of 2008 gave a minimal increase in average premium, while the health and safety lockdown in 2021 inversely gave the highest spike since the turn of the century. Every American feels each nationwide effect, and communities are susceptible to local changes.

Depending on the underwriting guidelines permitted by individual state regulations, factors that influence the cost of insurance may include:

* The age and construction of a home;
* Proximity to a coast or other natural hazards (e.g., fault line, wildfire zone);
* Fire safety features such as smoke detectors or sprinklers;
* Anti-theft features such as off-site alarms or strong doors and deadbolts;
* The loss history of the homeowner and property; and
* Credit-based insurance score.

Although the cost of insuring homes is rising, managing insurance protection both preserves coverage for a real disaster and helps save money, offsetting higher insurance costs, according to the I.I.I.

Umbrella claims have doubled between 2010 and 2020, with payouts increasing by 67 percent, averaging $500,000 for each claim. The majority of claims stem from auto accidents, though claims such as dog bite settlements and internet libel and slander claims are on the rise.

Risk exposure is a method of both determining the cost and coverage requirements for umbrella insurance. Total assets, potential risks such as rental properties and teenage drivers, occupation, and lifestyle factors can increase liability exposures. Location, discounts for bundling with other insurance policies, accident history, and additional protections will likewise affect an individual's rates, and should be considered when determining the cost and level of coverage.