

Ethics, Laws, & Rules

Course Manual

3 credit hours—online



**mountain
ce**

Table of Contents

Important Information	iii
Course Objectives.....	iii
Course Intent.....	iii
1—Ethical Considerations	1
Philosophical Ethics.....	1
Normative Ethics	1
Virtue Ethics	2
Modern Ethics	3
Teleology	3
Deontology.....	3
Core Values	4
Social Values	4
Personal Values.....	5
Being Ethical.....	6
Rationalization	6
Comparing Us to Others	7
Momentum	7
Ethical Dilemmas.....	7
Ethics Compared to the Law.....	9
2—Insurance Ethical Considerations	11
Why Should Insurance Professionals Study Ethics?	11
Expectations of Insurance Professionals	11
Fiduciary Responsibility	12
Trust in the Insurance Business.....	13
Insurance Ethics Compared to Insurance Law	14
Insurance Ethics.....	15
Code of Ethics.....	16
Agent Authority.....	17
3—Federal Insurance Regulation	19
McCarran-Ferguson Act	19
Federal Trade Commission (FTC)	20
Health Insurance Portability & Accountability Act (HIPAA).....	21
Gramm-Leach-Bliley (GLB) Act.....	22

National Do Not Call Registry	24
USA Patriot Act	26
Terrorism Risk Insurance Act (TRIA) of 2002	28
4—Utah Insurance Code.....	32
Purposes (31A-1-102).....	32
Use of Social Security Number (31A-21-110).....	32
Revocation or Suspension of License (31A-23a-111).....	33
Continuing Education Requirement (31A-23a-202)	35
Trust Obligation for Funds Collected (31A-23a-409).....	36
Premium Received Forwarded (31A-23a-411.1)	37
Business Address and Records (31A-23a-412)	37
Fraudulent Insurance Act (31A-31-103)	39
5—Utah Insurance Rules	40
Introduction.....	40
Advertisements of Insurance (R590-130)	40
Unfair Marketing Practices (R590-154)	44
Fiduciary and Trust Account Obligations (R590-170).....	49

Important Information

Course Objectives

- Provide continuing education for insurance agents
- Present ethical considerations
- Create an awareness of federal laws and state regulations

Course Intent

Mountain CE, LLC does not render legal services or advice. This course is not intended as an authority on legal matters.

Any laws, rules, and regulations cited in this course have been edited and summarized—it would not be practical to publish them in their entire and original form. Furthermore, only a small subset of the numerous laws, rules, and regulations affecting the insurance industry are presented in this course. Our goal is to efficiently present the information most relevant to insurance agents in the short amount of time we have.

We have attempted to provide the most accurate information available. As rules, regulations, and industry practices change, some aspects of this course may become outdated. This course will be updated on a periodic basis as deemed necessary.

1—Ethical Considerations

Philosophical Ethics

The origin of the word **ethics** comes from the Greek word **ethos**, which means **character**. Ethics is a branch of philosophy that studies human values and conduct. Ethics is more abstract than other sciences such as mathematics, biology, or chemistry. Therefore, it is common for people to differ about the basic fundamentals of ethics. When given an ethical problem to solve, people often disagree on the correct answer.

There are four main branches of philosophical ethics:

- **Meta-ethics** analyzes the deep meaning of words and statements related to ethics. It looks for universal truths, the role of God, and the purpose of reasoning and judgments. It addresses questions such as, “What does the word *good* mean?”
- **Descriptive ethics** looks at what people *actually do believe* to be right and wrong.
- **Normative ethics** is the study of what is right and wrong. It attempts to create guidelines or norms that direct our actions. The focus is on what people *should believe* to be right and wrong—instead of what people *do believe* is right and wrong.
- **Applied ethics** takes the outputs of normative ethics and applies them to real-world situations such as abortion, war, gay rights, euthanasia, health care, global warming, animal rights, gun control, and behavior in the workplace.

Normative Ethics

Normative ethics explores the responsibilities a person has to society. When studying normative ethics, we ask questions such as:

- Am I a good person?
- What is good and what is evil?
- What is right and what is wrong?
- What is the best thing to do in this situation?

The purpose of normative ethics is not to give us answers to all our ethical

questions. Instead it provides structure and order to how we think, talk, and act. It helps us to think clearly, understand what we believe, and make more rational decisions.

Studying normative ethics reminds people to consider the best interest of others and society as a whole when making decisions and conducting business. It helps to define the set of standards by which people live and do business.

There are three major theories of normative ethics: virtue ethics, teleology, and, deontology.

Virtue Ethics

Socrates, Plato, and Aristotle were ancient Greek philosophers who lived about 470 BC to 322 BC. Socrates was Plato's teacher, and Plato was Aristotle's teacher. Collectively, these three men are often given credit for laying the groundwork for "Western" culture and **virtue ethics**.

Plato taught there were four virtues: wisdom, courage, temperance, and justice. He said the most important is wisdom, which is knowledge of what is good. Later, Aristotle added additional virtues such as friendliness, wit, truthfulness, and generosity. In the New Testament, Paul describes three more virtues: faith, hope, and charity (1 Corinthians 13:13).

The focus of virtue ethics is on a person's character—instead of consequences and rules. By studying virtue ethics, we examine desirable qualities that people should exhibit. Some examples: we should be educated, keep our cool, be brave, don't lie, be nice, and play fair.

Virtue ethics stresses the value of developing superior habits of character, such as kindness. For example, if I acquire the habit of kindness, then out of habit I will act in a kind manner.

Plato and Aristotle taught that **eudaimonia** is the ultimate goal for all humans. "Eudaimonia" means "human flourishing." For a virtue ethicist, eudaimonia is the state achieved by someone who lives the proper human life, which can only be achieved by practicing the virtues. There is a distinction between primary and secondary goals. For example, why do I go to work? Do I work so I can work? Or, do I work so I can earn money, so I can provide for my family, so I can achieve a certain level of satisfaction? Virtue ethicists say that we are motivated by eudaimonia—and that the purpose of everything we do is for that end goal.

Critics of virtue ethics say it does not go far enough to help us solve the complex problems of today's world. They say we need more modern ways to analyze ethical considerations.

Modern Ethics

The study of ethics as we know it today (modern ethics) began to take shape in the 16th century. It attempts to tackle more complicated issues. One of the most common arguments modern philosophers and ethical scholars have is whether people's actions are driven by: (1) the **benefits** that might be received, or (2) the **obligations** they have. In other words, the question is, "Do people do things because they want to, or because they believe they are obligated to satisfy a duty?"

Teleology

Teleology is a belief that any judgment on whether an action is right or wrong depends on the **benefits** ultimately produced by the actions. In other words, what will the end result be? For example, although killing and lying are generally wrong, a murder or lie might be justified if it results in an overall benefit.

A teleologist might say that it's okay to kill if it's in self defense or for euthanasia. Furthermore, it might be okay to tell someone recovering in the hospital, "You look great," when she really looks terrible. When we make a choice that leads to a desirable result, then we are ethical. Teleologists believe that the end justifies the means.

Consequentialism, utilitarianism, and relativism are theories of similar beliefs.

Deontology

Deontology is a belief that a verdict about whether something is right or wrong doesn't depend on the good or bad it may—or may not—produce. Rather the focus is on the **obligations** or **duties** we have to satisfy specific rules and laws. The spotlight is on the input rather than the output.

Although we all want good outcomes, we cannot predict the future. Therefore, since we generally agree that killing and lying are bad, we might conclude, "Who is to say that killing and lying are okay in certain situations?" Deontologists say that people should be judged by an impartial and objective determination of good and evil. Actions that are wrong (e.g. killing, lying) are wrong—it isn't relative to the situation. When we make a choice that does not violate a general rule or duty, then we are ethical.

One of the greatest deontologists was the German philosopher of the 1700's, Immanuel Kant (1724-1804). He said that the only test of whether an action is right or wrong is if it could be applied to everyone. For instance, if everyone consistently lied and killed, our world would be in total chaos. Therefore, it is

wrong to lie and kill.

Another belief with similar views is **absolutism**.

Core Values

According to the famous author C. S. Lewis (1898-1963), “Human beings, all over the earth, have this curious idea that they ought to behave in a certain way, and cannot really get rid of it.”

In other words, Lewis said that there’s something inside us that give us direction on what is right and what is wrong. Some would say that “thing” is our conscience. Others might describe it as the “Spirit” inside us. That being said, it is an undeniable fact that our environment plays a huge role in the development of who we are, how we behave, and how we treat others.

A human’s behavior is influenced by his or her **core values**. Throughout their lives, people pick and choose the core values they want to follow from the “cafeteria” of possible values. This cafeteria includes the culture we live in and the organizations we belong to.

Our culture is shaped by our family, and friends. Our parents (or guardians who raised us) probably have the biggest impact of all. It is common for people to have many of the some beliefs and habits that their parents have. When it comes to friends, “peer pressure” is more than just a play on words.

Organizations include schools, religious institutions, businesses, associations, and governments. The influence of schools is significant—it’s been said that all our key behaviors are learned in kindergarten. Countless people turn to their religious scriptures for guidance. Businesses and professional associations have “codes of conduct.” Furthermore, the Constitution of the United States provides direction on the rights and responsibilities of governments and individuals.

Core values can be separated into two groups: **social values** and **personal values**.

Social Values

It is easy to come up with a list of core values that most Americans would agree are in the best interest of our society:

- **Integrity**—honesty, having strong beliefs, courage, and conviction
- **Faithfulness**—keeping promises; being patriotic, loyal to friends, family, and employer

- **Privacy**—respecting confidential matters
- **Support**—providing aid, comfort and companionship to others; especially friends and family
- **Fairness**—treating people equally
- **Respect**—recognizing that all people are important and have dignity
- **Safety**—protecting people from harm
- **Health**—having a society that is healthy, fit, and mobile
- **Life**—respecting the dignity of human existence
- **Work**—taking pride in one’s work; earning a fair wage; providing for oneself and family
- **Time**—being prompt; not having our time wasted
- **Accountability**—accepting responsibility for one’s actions or inactions
- **Education**—allowing people to reach their full potential
- **Democracy**—recognizing the importance of a society where people can choose their own government
- **Competition**—creating a level playing field; playing fair; allowing consumers to have options; comparing our results with the results of others; keeping score to determine the winner

Personal Values

In addition to the above list, there are additional core values that people pursue:

- **Freedom**—being able do as one pleases
- **Wealth**—accumulating money and other assets; striving for financial independence
- **Power**—controlling the actions of others
- **Winning**—being first or being “right”
- **Pleasure**—enjoying life and what it has to offer
- **Status**—achieving a certain class or level of prestige; being held in high regard

- **Not getting caught**—hiding our faults and transgressions from others so we are not penalized for them

This list of core values is more self-serving than the first list. In other words, they are personal desires or **personal values**. Most of these desires are not inherently bad. However, people struggle daily with balancing their pursuit of personal desires with the goal of trying to satisfy all the social values that most of us subscribe to.

Being Ethical

It is important to make the distinction between values and ethics. **Values** are things a person believes are very important to him or her. **Ethics** is what a person does—or does not do—as it relates to his or her **values**. The social values previously listed are useless unless they are practiced. When a person acts in such a way that does not compromise any of the social values, we consider that action to be ethical. Although people usually agree on what the social values are, disagreements often erupt over whether or not a particular action compromises one or more of the social values.

It would be an amazing feat for a person to live their entire life without ever compromising the best interests of others. Since our society is made up of human beings—flawed creatures—the best we can really hope for is that most of the people are ethical most of the time. A cynical view—you might say? Yes, perhaps. But if we take that view, it liberates us and allows us to understand that no matter how good or ethical we think we are, there is always room for improvement. That view also gives us an incentive to study ethics to further develop our ethical behavior.

Rationalization

When people try to justify unethical behavior it is called **rationalization**. Here are some examples that illustrate the rationalization of unethical behavior:

- A company promises its workers a certain level of benefits for the next three years. One year into the agreement, the company reduces the benefit package and cites changes in economic conditions as the reason for the change.
- An employee routinely inflates her travel expense report. She believes she deserves the extra money because of all the time she spends away from her family while traveling on business.
- An employee cheats on his production report because his peers cheat on

their production reports. He thinks that if he doesn't cheat, his reported production will be low in comparison to that of his co-workers.

Comparing Us to Others

Suppose you asked 100 people this question, "Are you more ethical than other people, less ethical, or the same?" It's a safe bet that a vast majority of folks would say they are more ethical than others, and very few would say they are less ethical than other people. How can that possibly be? There are probably multiple reasons for this phenomenon:

- Our news media bombards us with headlines of mildly or highly crazed members of our society who do strange, corrupt, and sometimes evil deeds. If we put these people in our peer group and compare ourselves to them, we don't seem so bad.
- It is human nature for people to think their own interpretations and applications of the core values are more correct than others. People crave their own self-respect. If a person does not have self-respect, how can he/she look in the mirror each day?
- We tend to judge our own behavior by our intentions. However, we often judge the behavior of others by their actions, because we often don't know their intentions. Because people are flawed, human intentions are frequently better than their actions.

Momentum

When watching or listening to a sporting event, we often hear the word momentum. A team with momentum that is headed in a certain direction is tough to stop. The same holds true for ethics. If a professional is headed in the right direction regarding ethics, he or she is likely to keep going in that direction. The opposite is true for professionals who are headed in the wrong direction. If a person starts out being unethical in small matters, it's easy to make it part of his or her normal routine and often escalates into more serious wrongdoings.

Ethical Dilemmas

Doing the right thing is relatively easy—when the difference between right and wrong is clear. **Ethical dilemmas** occur when the difference between right and wrong is not so clear. This may happen when two or more of a person's values conflict with each other. Consider the following situations:

- Karen values **friendship** and also **human wellness**. George confides to his friend Karen that he uses illegal drugs. George makes it clear to Karen that if she tells anyone, they will no longer be friends. Karen feels she should inform George's parents of the drug use, but she does not want to jeopardize the relationship. Should Karen tell George's parents?
- Bill values his **job** and also the time he spends with his **family**. On Thursday, Bill promises his kids he would take them to a ball game on Saturday. On Friday, Bill is told by his boss that he must work on Saturday. Should Bill work on Saturday—or take his kids to the ballgame as he promised?
- Sue values **honesty** and also the **safety of her children**. In most situations, Sue would never tell a lie. However, what if the safety of her child was at stake if she told the truth? Should she tell a lie to protect her child's safety?
- Joe values **employment** and also **integrity**. Joe works for a company that requires him to conduct business in a dishonest manner. Joe is uncomfortable with the situation, but it will take him months to find a new job. His family desperately depends on his income. Should Joe quit his job—even before he can find a new one?
- Ann values **human safety** and also **privacy**. She suspects a woman in her neighborhood is a victim of domestic violence. Ann's neighbor acts scared and has bruises. When Ann asks the woman about it the woman replies, "Everything is fine—I just slipped and fell." Should Ann call the police?

Whenever a question arises that involves a choice between two or more outcomes, it is human nature to want to know: What is the correct answer? However, for a question involving an ethical dilemma, it is usually difficult to pick the correct answer. That's because if a situation presents a clear distinction between right and wrong, then it is not an ethical dilemma to being with. Ethical dilemmas involve a person having to make a choice between two or more values. Most people resolve ethical dilemmas by asking themselves these questions:

- Do I have enough information to make this decision?
- What is the best possible outcome—short-term and long-term?
- Who will be damaged—and how much will they be damaged—if I pursue a particular course of action?
- Am I treating others the way they want to be treated?

- Which value is more important to me in this situation?
- Which value must be compromised in this situation so another value can be satisfied?

Ethics Compared to the Law

Is ethics the same thing as the law? No, not exactly, but asking that question raises some interesting points. Some people view ethics as doing the right thing, even though they are not required by law to do the right thing.

The biggest difference between laws and ethics is that laws are documented in writing; therefore, most people agree on what the laws dictate. When it comes to the law, we all play by the same rule book. However, when it comes to ethics, we don't all have the same rule book and quite often we disagree about what is ethical.

Consider the following chart:

	Ethical	Unethical
Legal	YES	?
Illegal	?	YES

It is easy to think of examples of actions that satisfy the following criteria:

- Ethical and legal (e.g. paying taxes, obeying traffic laws)
- Unethical and illegal (e.g. murder, stealing)

However, we must think harder to produce examples of actions that satisfy the following criteria:

- Unethical but legal (?)
- Ethical but illegal (?)

Any in-depth discussion by people of diverse backgrounds to resolve the above question marks will surely lead to debate. Here are some controversial positions people may have:

- The opinion that abortion is unethical—even though it is legal

- The opinion that capital punishment is unethical—even though it is legal
- The opinion that talking on the cell phone is unethical—even though it is legal in most places
- The opinion that it is ethical to speed—because everyone else does it
- The opinion that it's ethical to bomb an abortion clinic—even though it is illegal
- The opinion that civil disobedience and destruction of property to protest war is ethical—even though it is illegal

Why are the above positions controversial? Because, although people generally agree on what the laws are and know if an action is legal or not, they often disagree whether or not a particular action is ethical or not ethical.

2—Insurance Ethical Considerations

Why Should Insurance Professionals Study Ethics?

In December 2006, a nationwide poll was conducted to rate the ethical standards of 23 professions. Of those 23 professions, insurance salespeople finished fourth last! Only 13% of the respondents rated insurance agents as having high or very high ethical standards!

Insurance companies are popular targets of lawsuits, court orders, fines, and penalties. Consider a few examples of recent legal actions:

- An insurance company recently settled a race-based life insurance lawsuit for \$160 million. The company was accused of charging blacks more premium than whites for the same policy.
- The state of Ohio fined a company \$30,000 for using unlicensed agents to sell insurance.
- A jury ordered a health insurance company to pay a Texas widow more than \$13 million in damage for denying treatment.
- The state of Minnesota fined an insurance company \$80,000 for sending deceptive credit authorization forms to its policyholders.
- A large insurance company agreed to settle a class action lawsuit related to Hurricane Katrina, which could cost the carrier more than \$130 million.

According to the National Association of Insurance Commissioners (NAIC), each year approximately 200,000 formal complaints are filed by consumers against their insurance companies. The top three complaints are delays, claim denials, and unsatisfactory settlements.

Each year more than 100 insurers, agencies, and individuals are cited by the Utah Insurance Department for failure to follow insurance laws and rules. Recent enforcement actions are listed on the following web-site:

<http://www.insurance.utah.gov/Enforcement.html>

Expectations of Insurance Professionals

As it relates to the insurance industry, **ethics** is the **set of core values** used by insurance professionals to guide their conduct. Ethics is important in helping to distinguish between right and wrong when managing insurance transactions.

Insurance is one of the most important industries in our society. Insurance is a financial product that protects our most important assets. Without the financial security insurance provides, many people would not be able to own a home, drive a car, receive quality medical treatment, or send their children to college. Therefore, it could be argued that insurance professionals are held to a “higher standard” than many other workers in our society. Insurance agents are often expected by the public to be financial counselors—instead of merely salespeople.

Insurance agents have the opportunity to earn and maintain a reputation as being a trusted advisor. The public depends on the integrity of insurance agents to safeguard their way of life. People rely on insurance agents to protect their incomes, homes, cars, and health—should death, accident, or other unforeseen event occur.

Fiduciary Responsibility

Insurance agents have fiduciary responsibilities to both the **customer** and the **carrier** (insurance company) they represent.

An insurance agent has a **fiduciary responsibility to the customer**. This means there is a strong relationship of trust, and the agent is expected to do what is best for the customer. The agent is expected to place more emphasis on considering the needs of the customer—instead of focusing on his/her own personal values and desires.

Furthermore, the agent must be knowledgeable—and be able to explain—the most important features of the products he/she has to offer. As a fiduciary, the agent must account for any money collected for an insurance transaction and promptly submit them to the carrier.

All customer money collected must be kept separate from the agent’s operating or person money. Failure to keep customer money separate is considered **commingling** of funds—which is highly illegal.

Insurance agents also have a **fiduciary responsibility to the carrier** they represent. They are expected to be the eyes, ears, and mouth of the carrier. Any thing significant the agent sees or hears, he/she is expected to convey to the insurance company.

The agent’s contract with the carrier will identify the agent’s responsibilities and duties. The agent must act in agreement with the contract for the benefit of the carrier. The agent is responsible for obtaining all necessary information from the applicant and to complete all applications and forms correctly—including gathering all the required signatures.

All pertinent information—especially information that affects underwriting and rating—must be disclosed to the carrier. All money and assets the agent holds in trust for the carrier must be cared for properly.

Having **fiduciary responsibilities to both customers and carriers** sometimes puts insurance agents in a compromising position. We don't live in a perfect world—what the customer thinks is right is not always the same as what the carrier thinks is right—and ethical dilemmas can result. Should the agent please the customer at the expense of the carrier? Or should the agent please the carrier at the expense of the customer?

It is vital that insurance agents understand they are accountable first to the party they are under contract with and appointed by. In a producer/carrier relationship, that is the carrier. Therefore, when a customer/carrier ethical dilemma emerges, it is seldom wrong for the agent to faithfully execute insurance transactions with the desires of the insurance carrier in mind.

Trust in the Insurance Business

Trust is of paramount importance when it comes to the insurance business. There are several reasons for this:

- Insurance policies and laws are complicated. Most insurance customers do not read their policies, and even more do not understand their policies. When people buy insurance, they are buying trust. They trust their insurance agent will educate them and explain the policies, coverages, and options. They trust their agent will complete the transaction with professionalism, accuracy, and integrity.
- Insurance customers must disclose a tremendous amount of personal and confidential information about themselves to their insurance agent. Depending on the type insurance being sold, this may include health history, hobbies, height, weight, personal choices such as tobacco and alcohol use, driving violations, claim history, income, savings, investments, marital status, children, age, social security #, drivers license #, credit information, etc.
- Consumers of insurance do not receive a tangible product in return for their premiums, as insurance is nothing more than a promise. Therefore, the public has a tendency to view their premiums as money down the drain—with no return on their “investment.” This attitude sometimes leads people to distrust insurance professionals.
- Quite often, people are under great stress when they are seeking the

benefits of an insurance policy. Therefore, they are likely to be more impatient, irritable, and ill-tempered than otherwise. The purpose of insurance is to *be there* when disaster strikes. Times of tremendous stress occur when someone is involved in an accident, when tragedy hits their home, is sued for negligence, has health problems, or experiences death of a loved one. The promises of insurance must be there for them.

- An insurance transaction can have great financial consequences. If a person buys insurance they don't need, it is a waste of the customer's hard earned money. Worse yet, if a person has the wrong insurance, not enough insurance, or no insurance all—that predicament can have devastating ramifications for a family for decades and perhaps generations.

Insurance Ethics Compared to Insurance Law

For many decades, our society has recognized the importance of a stable and fair insurance industry. If the insurance industry were left unchecked, consumers could be subject to unfair, unstable, and fraudulent practices. Therefore, insurance is a heavily regulated industry. In the United States, each state is charged with the responsibility of regulating the insurance business that is done within its border.

Now, let's consider the following chart within the context of *insurance*.

	Ethical	Unethical
Legal	YES	?
Illegal	?	YES

It is easy to think of examples of *insurance* actions that satisfy the following criteria:

- Ethical and legal (e.g. executing insurance transactions with integrity)
- Unethical and illegal (e.g. commingling funds, forging signatures, rebating)

Similar to when we used this chart before, we must think harder to produce examples of insurance actions that satisfy the following criteria:

- Unethical but legal (?)

- Ethical but illegal (?)

Some insurance professionals might incorrectly concentrate only on satisfying the letter of the law—instead of considering ethics—when looking for direction to guide their actions. Therefore, they may draw the following conclusions:

- It is legal to sell a product to a customer—even if it's not the right product for the customer.
- It is legal to sell a product to a customer—without properly educating the customer on what he/she is buying.

However, when examining Utah state insurance law (31A-23a-111), we find that the following behavior is illegal in the insurance business:

- *Has intentionally misrepresented the terms of an actual or proposed:*
 - *Insurance contract; or*
 - *Application for insurance*
- *Has admitted or been found to have committed any insurance unfair trade practice or fraud*
- *In the conduct of business in this state or elsewhere has:*
 - *Used fraudulent, coercive, or dishonest practices; or*
 - *Demonstrated incompetence, untrustworthiness, or financial irresponsibility*

Therefore, one may conclude that the state of Utah has legislated ethics in the insurance business. Admittedly, however, when it comes to insurance ethics—enforcing the law is no easy task.

Although trying to find an insurance action that is unethical but legal is difficult to do, trying to find an insurance action that is ethical but illegal is probably harder—if not impossible—to come by.

Insurance laws were made to protect society's best interests. Breaking an insurance law is **unethical**, because it compromises the well-being of society as a whole. Therefore, if an action related to insurance is **illegal**, it is also unethical.

The insurance laws are a good place for insurance professionals to start when it comes to following a set of standards to guide their conduct.

Insurance Ethics

It is difficult to prove with statistics that ethical insurance people are more successful than their unethical peers. However, since insurance sales are based on trust, common sense tells us ethical insurance professionals are more respected—and thus more successful. People are much more likely to purchase insurance from someone they know and trust.

A vast majority of insurance professionals are in it for the “long haul.” They live and work in the same communities as their clients. They attend the same community and social functions. While an unethical action might provide short-term financial rewards, unethical conduct certainly has its consequences. The long-term survival and success of an insurance agent is unquestionably dependent on ethical conduct.

Previously we discussed the dilemmas insurance agents on occasion face, since they have a fiduciary responsibility to both the customer and the carrier. That means an agent is required to do what is best for the customer—as well as act on behalf of the insurance company he or she represents. Sometimes these two goals conflict with each other.

Let’s suppose an insurance prospect has had a long history of claims—making her ineligible for insurance with this carrier. The client desperately needs insurance, and it would be in the best interest of that client to have insurance protection on her home. On the other hand, the agent is also required to represent the insurance company and follow the necessary underwriting guidelines. That means the agent must fill out the application truthfully and completely and comply with the company’s underwriting rules and procedures—even if it means the agent is unable to provide insurance protection for that client. In this situation the agent’s obligation (i.e. fiduciary responsibility) to follow the carrier’s underwriting rules outweighs the agent’s obligation to satisfy the customer.

Code of Ethics

In order to gain and maintain trust, insurance professionals need a set of standards that guide them in the work they do. It is not wise to merely rely on “gut feeling” or intuition. Having a set of standards allows us to think before we act and results in better decisions. Eventually, however, making the right choice can be developed to a level where it becomes second nature and can be accomplished without much thought. Getting to that level requires an understanding of the basic principles (core values) on which good decisions are based.

Previously in this course, we presented a list of core values the general public would agree on. Here is a list of **core values** that most insurance professionals

would agree on—related specifically to the work they do:

- Put the client's interests above the agent's own personal gain
- Analyze client needs and suggest the best coverage for the best value
- Document client discussions and decisions
- Be honest and exhibit integrity
- Protect confidential customer and company information
- Handle money properly and maintain sufficient accounting controls
- Act on behalf of the insurance company
- Execute insurance transactions competently
- Submit complete and accurate applications
- Avoid conflicts of interest and improper political lobbying
- Do not accept kickbacks and bribes
- Prevent harassment and discrimination
- Continue to learn about the insurance industry
- Understand state and federal regulations
- Comply with the law
- Do not speak negatively about competitors and their products
- Bring honor to the insurance profession

There are numerous professional insurance organizations that promote the advancement of ethical conduct. Each has developed a **code of ethics**, which is a list of standards for insurance professionals to follow. Based on these standards, most insurance companies have developed their own **code of ethics**—which they require their agents and employees to follow. Insurance agents too are challenged to develop a **code of ethics**—which is based on the standards of insurance organizations and companies. Regardless of who develops a **code of ethics**, these standards reflect many of the **core values** presented in this section.

Agent Authority

Insurance companies grant insurance agents the authority to act on their behalf.

When agents exercise their authority, their actions are considered to have been performed by the insurance company. For instance, if an agent accepts a premium payment from an insured, it has the same significance as if the insured paid the money directly to the insurance company. In many sales situations agents have the authority to **bind coverage**, which means temporary insurance coverage is provided until the insurance company issues or denies the policy.

Generally, there are three types of authority that insurance agents have:

- **Express authority**—the authority that is spelled out in the written contract between the insurance company and the agent. For example, the contract may indicate the agent is authorized to sell certain insurance products in a specific geographical area.
- **Implied authority**—the authority an insurance company intends the agent to have, but is not expressed in writing. There is a need for implied authority, since it is impossible to write a contract that spells out every possible scenario that may occur. Implied authority is granted based on previous words or actions of the insurance company. For instance, Jane is an agent for Rietbrock Insurance Company and is expected to generate new business. She most likely has implied authority from Rietbrock Insurance Company to set up a booth at a county fair to represent and promote Rietbrock Insurance—even though that specific action is not expressly authorized in the agent contract.
- **Apparent authority**—a legal doctrine stating that an agent has whatever authority a reasonable person would think the agent has. For example, Bill is an agent with Black Creek Insurance Company. Suppose a customer calls Bill and describes an accident she was in. Further suppose that Bill assures the customer that the claim will be paid. In reality, Bill as a sales agent, does not have the authority to settle claims. But, because Bill represents Black Creek Insurance Company, the claim would probably have to be paid—even if the policy stated otherwise. Because a reasonable person might think Bill has the authority to settle claims, the company he represents is bound by Bill's actions.

The authority of insurance agents has significant ethical implications. Their actions are a true reflection of: (1) the insurance companies they represent, (2) other insurance agents, and (3) the insurance business as a whole. Therefore, insurance agents have an ethical duty to act in such a way to bring honor to the companies and industry they symbolize.

3—Federal Insurance Regulation

Only a small number of the many federal regulations affecting the insurance industry are presented in this course.

McCarran-Ferguson Act

The **McCarran-Ferguson Act**, passed by Congress in 1945, defined the roles of state and federal governments regarding insurance regulation.

- It provides insurance companies with limited exemptions from federal antitrust laws—to the extent that it is regulated by the states. These exemptions allow insurance companies to share historic loss information to better project future losses and charge more accurately for their products. It also means insurers can work together to develop insurance policy forms.
- It gives each state the power and responsibility to regulate insurance business that is conducted inside its borders. Examples of this responsibility include:
 - Examine and approve property and casualty insurance forms and rates filed by the insurance companies
 - Respond to legal questions about insurance
 - Regulate the licensing for insurance professionals and organizations, including initial licenses, renewal licenses, and continuing education
 - Determine which insurance companies are authorized to conduct business in the state
 - Analyze and verify the financial information of insurance companies; identify insurance companies who have financial difficulties and assist in rehabilitation; manage liquidation of insolvent insurance companies
 - Provide assistance to consumers by handling complaints and inquiries
 - Enforce compliance with insurance code and rules; conduct fraud investigations and prosecute individuals, organizations, and companies who violate insurance law; violators are subject to

license suspension, license revocation, fines, or jail time

Although the insurance industry has been primarily regulated by individual states for many decades, critics of the current system say it suppresses competition and is overly complicated and burdensome. Many insurance organizations and companies have endorsed changes that would allow for more unified regulation at a nationwide level.

In May 2007, Sen. John Sununu (R-NH) and Sen. Tim Johnson (D-SD), introduced a bill to establish an optional federal insurance charter and a federal insurance regulator. If the bill becomes law, an insurance company with a national license would not need individual state licenses to write insurance and would be exempt from most state insurance laws. It would also create a National Insurance Commissioner who would be appointed by the President for a five-year term. The National Association of Professional Insurance Agents (PIA), the Independent Insurance Agents and Brokers of America (IIAB), and the National Association of Mutual Insurance Companies (NAMIC) are against this proposed legislation. On the other hand, the American Insurance Association (AIA) and the National Association of Insurance and Financial Advisors (NAIFA) are in favor.

In March 2007, the antitrust issue was discussed by the Senate Judiciary Committee. Legislation has been introduced in both the Senate and House to repeal the insurance industry's limited antitrust exemption. Opponents of the limited antitrust exemption argue repeal is necessary because they say insurers collusively set prices above competitive levels. They say some states are not doing a good job of regulating rates. The assertion of collusion has been fueled by the use of rate service organizations such as the Insurance Services Office (ISO), which pools loss data from many insurers, analyzes the data, produces expected loss projections, and then publishes rates for participating carriers to use.

Federal Trade Commission (FTC)

The **FTC** is a federal agency responsible for:

- Protecting consumers against unfair, deceptive, or fraudulent practices
- Preventing business practices that restrain competition

As stated in the previous section, each state has the power and responsibility to regulate insurance. Each state, however, is only able to regulate the insurance business that is conducted inside its borders. Therefore, the **FTC** regulates the interstate commerce activities of insurance companies. Furthermore, the **FTC**

and other federal government agencies regulate the activities of insurance companies that are not unique to the insurance business—such as telemarketing, privacy, and credit scoring.

Health Insurance Portability & Accountability Act (HIPAA)

This section was based on information from the web site:

<http://www.hhs.gov/ocr/hipaa/>

The purpose of **HIPAA** is to amend the Internal Revenue Code of 1986 to:

- Improve portability and continuity of health insurance coverage in the group and individual markets
- Combat waste, fraud, and abuse in health insurance and health care delivery
- Promote the use of medical savings accounts
- Improve access to long-term care services and coverage
- Simplify the administration of health insurance

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (**HIPAA**) of 1996 included the words “simplify the administrative of health insurance.” That required the Department of Health and Human Services (**HHS**) to adopt national standards for electronic health care transactions. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into **HIPAA** provisions that mandated the adoption of federal privacy protections for individually identifiable health information. In response to the **HIPAA** mandate, **HHS** published a final regulation in the form of the Privacy Rule in December 2000, which became effective on April 14, 2001. This Rule set national standards for the protection of health information, as applied to the three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct certain health care transactions electronically.

The **Privacy Rule** states that health insurance companies and HMOs are required to protect the following customer information:

- Information about doctors, nurses, and other health care providers put in the customer’s medical record
- Conversations the customer’s doctor has had about care or treatment with

nurses and others

- Information about the customer in the health insurer's computer system
- The customer's health clinic billing information

Health insurers who are required to follow this law must comply with a customer's right to:

- Ask to see and get a copy of their health records
- Have corrections added to their health information
- Receive a notice that tells how health information may be used and shared
- Decide if permission is needed before health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why health information was shared for certain purposes

If a customer believes his or her rights are being denied or health information isn't being protected, a complaint can be filed with the health insurer and/or the United States government.

Gramm-Leach-Bliley (GLB) Act

This section was based on information from the web site:

<http://www.ftc.gov/privacy/glbact/>

The **Financial Modernization Act of 1999**—also known as the **Gramm-Leach-Bliley Act** or **GLB Act**—allowed financial service organizations such as banks, securities dealers, and insurers to sell each other's products. The Act includes privacy provisions to protect consumers' personal information held by financial institutions. The intent is to prevent the abuse of customer information.

The **GLB Act** gives authority to eight federal agencies and the states to administer and enforce the **Financial Privacy Rule** and the **Safeguards Rule**. These two regulations apply to "financial institutions," which includes banks, securities firms, insurance companies, and companies providing other types of financial products and services to consumers. These rules also apply to companies—whether or not they are financial institutions—who receive such information.

- The **Financial Privacy Rule** governs the collection and disclosure of

customers' personal financial information by financial institutions.

- The **Safeguards Rule** requires all financial institutions to design, implement and maintain safeguards to protect customer information.

The primary concern of the two rules is the regulation and protection of “nonpublic” personally identifiable information including the customer’s name, address, policy information, date of birth, driver’s license number, credit card account information, bank account information, payment and credit history, payroll information, and social security number.

The **GLB Act** privacy rules require insurance companies and its workers to:

- Disclose their privacy procedures to policyholders when they become customers and then annually thereafter for as long as they are a policyholder
- Take measures to help customers understand the privacy procedures
- Gather and use customer information only for the business use of the insurance company
- Implement procedures that ensure only complete and accurate customer information is collected, retained, and used and prevent against accidental loss of customer data
- Prevent illegal and unauthorized access to customer data and make sure only employees and agents who have a legitimate business need are able to access customer information
- Require third parties who lawfully receive customer information from the insurance company to also follow the privacy rules
- Prevent the sharing of customer information with third parties for marketing purposes without customer consent

Insurance agents and other workers who handle customer information need to take these specific precautions to comply with the **GLB Act**:

- Protect the security of desktop computers, laptops and handheld devices that contain customer information
- Change computer passwords regularly and make them easy to remember but difficult for someone else to guess
- Do not share computer passwords with another person
- Change computer passwords when it is suspected someone else has

violated the password

- Put password protection on voice mail boxes that may contain customer information
- Protect the security of incoming and outgoing mail
- Do not leave customer information unattended and lock up customer information before leaving
- Protect customer data when unauthorized visitors are in the work area
- Ensure unneeded customer information is disposed of in a safe manner such as shredding
- Regularly backup customer data and make sure backed up data is secure
- Verify the identity of a person who requests information about a customer and do not disclose the information to someone who is not authorized to receive it

It is usually permissible for insurance workers to disclose customer information to third parties such as:

- Police and other law enforcement officials for policy verification or investigation purposes
- Lenders such as mortgage companies and vehicle lienholders; the amount of information shared must be limited to only the amount needed to complete the transaction
- Other insurance companies and independent adjusters for the purpose of claim processing
- Businesses such as hospitals, clinics, contractors, auto body repair shops, restoration, and glass companies for the purpose of verifying policy coverage and benefits
- Insurance regulatory agencies
- The policyholder's attorney if the attorney provides proof of representation

National Do Not Call Registry

This section was based on information from the web site:

<http://www.ftc.gov/donotcall/>

The **National Do Not Call (DNC) Registry** is a list of phone numbers from consumers who have indicated their preference to limit unwanted telemarketing calls. The registry is managed by the Federal Trade Commission (**FTC**), the nation's Consumer Protection Agency. It is enforced by the **FTC**, the Federal Communications Commission (**FCC**), and state officials. The registry was created in 2003 to offer consumers a choice regarding telemarketing calls.

The **DNC** provisions of the Telemarketing Sales Rule (**TSR**) cover any plan, program or campaign to sell goods or services through phone calls. This includes calls by telemarketers who solicit consumers, often on behalf of third party sellers. It also includes sellers who are paid to provide, offer to provide, or arrange to provide goods or services to consumers.

When making the following types of calls, organizations are not required to access and check numbers on the National DNC Registry:

- Calls from non-profit charities
- Political polls
- Surveys
- Business-to-business calls
- Calls to people that the caller has received written permission to call
- Calls to people that the caller has an established business relationship with

A company with which a consumer has an established business relationship may call for up to **18 months** after the consumer's last purchase or last delivery, or last payment, unless the consumer asks the company not to call again. In that case, the company must honor the request not to call.

If a consumer makes an inquiry or submits an application to a company, the company can call for **three months**. Once again, if the consumer makes a specific request to that company not to call, the company may not call, even if it has an established business relationship with the consumer.

A consumer whose number is not on the national registry can still prohibit individual telemarketers from calling by asking to be put on the company's own do not call list.

Consumers can register their home phone numbers and their cell phone numbers by dialing **1-888-382-1222** or by visiting www.donotcall.gov. The National DNC Registry is only for personal phone numbers, since business-to-business calls are not covered by the DNC legislation.

Access to the National DNC Registry is limited to sellers, telemarketers and other service providers. The registry may not be used for any purpose other than preventing telemarketing calls to the telephone numbers on the registry.

Access to the National DNC Registry data for up to five area codes is free. The annual fee is \$40 per area code of data (after five), with a maximum annual fee of \$11,000 for the entire U.S. database.

Telemarketers have to synchronize their lists with an updated version of the registry at least every **31 days**.

Any telemarketers calling U.S. consumers are covered by DNC, regardless of where they are calling from. If a company within the U.S. solicits sales through an overseas professional telemarketer, that U.S. company may be liable for any violations by the telemarketer. The FTC can initiate enforcement actions against such companies.

Violators may be subject to fines of up to **\$11,000 per violation**. Each call may be considered a separate violation.

A company that is a seller or telemarketer could be liable for placing any telemarketing calls (even to numbers NOT on the registry) unless the seller has accessed the registry and paid the fee, if required.

USA Patriot Act

This section was based on information from the web sites:

http://www.fincen.gov/pa_main.html

<http://www.ustreas.gov/offices/enforcement/ofac/>

In October of 2001, the United States government enacted the **Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT)** Act. Its intent is to deter and punish terrorist acts in the United States and around the world, and to enhance law enforcement investigatory tools. The United States Treasury Department has issued a rule implementing a key provision of the **USA PATRIOT** Act aimed at preventing money laundering and terrorist financing. (Money laundering is using financial transactions to convert money obtained from illegal activity into money that appears to be legal—so its illegal source cannot be traced.)

The rule requires insurance companies to establish an anti-money laundering program, as specified under section 352 of the Act. For this purpose, insurance companies are defined as life insurance companies and any other insurance company that offers products with investment features or features of stored value

and transferability. Under the rule, a company must establish and maintain a written anti-money laundering program that at a minimum:

- Incorporates internal policies, procedures, and controls based on the company's assessment of its money laundering risks
- Designates a compliance officer
- Establishes an ongoing employee training program
- Establishes an independent audit function to test programs

The Office of Foreign Assets Control (**OFAC**) of the U.S. Department of the Treasury administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries, terrorists, international narcotics traffickers, and those engaged in activities related to the proliferation of weapons of mass destruction. **OFAC** is responsible for maintaining the terrorism watch list of Specially Designated Nationals (**SDN**) and blocked persons. This list has names of individuals, organizations, and countries that sponsor terrorism and other illegal acts. As of July 2007, the list was contained about 10,000 names. The list can be accessed from the following web-site:

<http://www.ustreas.gov/offices/enforcement/ofac/sdn/index.shtml>

The **USA PATRIOT** Act requires life insurance companies—and any other insurance company that offers products with investment features or features of stored value and transferability—to do the following:

- Verify the identity of all individual and commercial clients
- Check to see if each client they exchange money with is on the **OFAC** terrorism watch list of Specially Designated Nationals (**SDN**) and blocked persons
- Do not insure or make payments to individuals and organizations identified on the **OFAC** terrorism watch list
- Identify, share, and report suspicious activities such purchasing expensive insurance policies with cash and canceling a policy soon after it was issued—especially if the insured requests the refund go to someone other than the purchaser

To comply with these requirements, insurance companies must have a method for employees and agents to check clients against the **OFAC** terrorism watch list.

Opponents of the USA Patriot Act—such as the American Civil Liberties Union

(ACLU)—say it goes too far in allowing the government to conduct surveillance, wiretapping, harassment, secret searches, and access to highly personal medical, educational, and financial records with minimal judicial controls.

The USA Patriot Act was originally set to expire on December 31, 2005. Just days before it expired, it was extended by Congress to February 2006 and later extended to March 2006. In March 2006, Congress approved—and the President signed into law—the **USA PATRIOT Improvement and Reauthorization Act**. This act made changes to the original act including 27 civil liberties protections. Most of the renewed act's provisions were made permanent--three will be reviewed in 2010.

During the reauthorization signing ceremony, President Bush's comments included the following:

“The Patriot Act was passed with overwhelming bipartisan support. It strengthened our national security in two important ways: First, it authorized law enforcement and intelligence officers to share vital information. Before the Patriot Act, criminal investigators were often separated from intelligence officers by a legal and bureaucratic wall. The Patriot Act tore down the wall. And as a result, law enforcement and intelligence officers are sharing information, working together, and bringing terrorists to justice.

Secondly, the Patriot Act has allowed agents to pursue terrorists with the same tools they use against other criminals. Before the Patriot Act, it was easier to track the phone contacts of a drug dealer than the phone contacts of an enemy operative. Before the Patriot Act, it was easier to get the credit card receipts of a tax cheater than trace the financial support of an al Qaeda fundraiser. The Patriot Act corrected these double standards, and the United States is safer as a result.”

Terrorism Risk Insurance Act (TRIA) of 2002

This section was based on information from the web sites:

<http://www.iii.org>

<http://www.treas.gov/offices/domestic-finance/financial-institution/terrorism-insurance/%20>

According to the **Insurance Information Institute**, “The September 11, 2001 terrorist attack resulted in an estimated \$31.6 billion in insured losses. Those losses occurred across many types of coverage, including commercial property, business interruption, workers compensation, aviation, life and disability insurance. Future attacks on U.S. soil are also likely to trigger a wide range of insurance coverages, depending on the type of event and whether policyholders

have purchased terrorism insurance.”

Most homeowners and renters policies provide coverage for damage due to explosion, fire, and smoke—which would be the probable result of a terrorist attack. Personal auto policies provide coverage under comprehensive for terrorist damage to vehicles. Life insurance policies also provide coverage for death due to terrorism.

Up until a few years ago, most commercial insurance policies also included terrorism coverage. That way of thinking changed after September 11, 2001. Recognizing the enormous commercial terrorism exposure, many insurance companies added terrorism exclusions on their commercial policies. (Workers compensation policies did not, and do not, exclude coverage for acts of terrorism and war. Coverage for terrorist or war acts cannot be excluded from workers compensation policies in any state.)

In November 2002 the federal government enacted the **Terrorism Risk Insurance Act (TRIA)**. **TRIA** forms a partnership between the federal government and the commercial insurance industry to share the risk of terrorism. The program ensures adequate resources are available for businesses to rebuild if they are victims of a terrorist attack. This is accomplished by making property and casualty commercial insurance coverage for terrorism risk available and affordable.

Lines excluded from the program include: personal auto, home, farm, commercial auto, health, medical malpractice, life, assumed reinsurance, crop, flood, mortgage, and financial guaranty.

TRIA requires insurers to offer commercial property owners the opportunity to purchase terrorism coverage on risks such as retail stores, offices, financial services, real estate businesses, utilities, apartments, warehouses, contractors, and factories. These customers who purchase commercial policies can either reject or accept (for an additional fee) the terrorism coverage. This coverage voids the terrorism exclusions—imposed by insurers on commercial policies after 9/11—for losses caused by certified acts or terrorism. Many mortgage companies are requiring their commercial customers to purchase terrorism coverage. In 2006 it was estimated that 59% of commercial insurance customers purchased terrorism coverage.

TRIA was originally set to expire on December 31, 2005. However, it was extended for two years, and is now set to expire on December 31, 2007.

According to the Insurance Information Institute www.iii.org web-site, these are the key provisions of the current law set to expire December 31, 2007.

- The triggering event, the threshold for the program to go into effect, rose from \$5 million under the original Act to \$50 million after March 2006. In 2007 the trigger rose to \$100 million. Only terrorist acts likely to produce total insurance industry losses above the threshold will result in payment of federal funds.
- Individual company deductibles — the amount an insurer must pay before the federal program kicks in — rose from 15 percent of commercial property/casualty insurance premiums in 2005 to 17.5 percent in 2006 and 20 percent in 2007.
- Copayments, the amount insurers must pay above their individual deductibles or retentions, stayed the same in 2006 as in 2005 — 90 percent federal/10 percent insurer — but rose to 85 percent/15 percent in 2007.
- The industry as a whole must cover a certain amount of the losses through deductibles and copayments. This amount, known as the insurance marketplace aggregate retention, rose from \$15 billion in 2005 and \$25 billion in 2006 to \$27.5 billion in 2007. If, when all the computations have been made, the retention is found to be below the \$27.5 billion threshold, the federal government can recoup the difference between the actual amount it paid and the required retention. The payment must come from a surcharge on commercial insurance policies not to exceed 3 percent of premium for insurance coverages that fall under the TRIA program. If the industry is found to have retained an amount that exceeds the threshold, federal expenditures may be recouped for amounts in excess of the threshold at the discretion of the Secretary of the Treasury.

According to the Insurance Information Institute www.iii.org web-site, a bill to renew TRIA for another 10 years, H.R. 2761, was introduced in the House in June 2007. The measure maintains the current deductible, or amount of losses an insurer must pay before the federal program kicks in, at 20 percent of commercial property/casualty insurance premiums, and copayments, or the percentage insurers must pay above the deductible, at 15 percent, with the federal government contributing the other 85 percent. The industry's aggregate retention, or amount the entire industry must pay, also remains at \$27.5 billion.

The bill also proposes the following changes:

- The elimination of the distinction between foreign and domestic terrorism;
- The addition of group life insurance to the types of insurance for which terrorism insurance coverage must be made available by insurers;

- A reduction in the size of the loss that would trigger the program from \$100 million to \$50 million, to make it less onerous for small insurers whose capital could be wiped out before losses reached the \$100 million trigger;
- Inclusion of coverage for nuclear, biological, chemical and radiological attacks (NBCR). The deductible for this coverage is lowered to 7.5 percent and the copayment is calculated on a five-point sliding scale, depending on the size of the loss, from 15 percent for losses under \$10 billion to 5 percent for losses over \$60 billion. The Treasury must certify whether the event involves weapons of mass destruction.
- Require studies on how to encourage greater development of the private market for terrorism insurance.

In order for coverage to apply under **TRIA**, an act of terrorism must be certified by Secretary of Treasury—in concurrence with the Secretary of State and the Attorney General—as having all of these characteristics:

- A violent act or an act that is dangerous to human life, property, or infrastructure, and the act is not committed as part of the course of a war declared by the Congress, and
- Resulting in damage within the United States, or outside of the United States in the case of an air carrier or vessel or the premises of a United States mission, and
- Committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

Insurance agents who sell commercial policies covered under TRIA must be aware of the following:

- An **Offer of Terrorism Insurance Coverage and Disclosure of Premium** notice is required at the time of quote, offer, or purchase—which the insured can either accept or reject in writing
- A separate notice is required for each policy that is quoted or written
- A signed notice must be attached to each policy application

4—Utah Insurance Code

Only a small number of the many Utah Insurance laws are presented in this course. For a complete listing, visit:

<http://www.le.state.ut.us/~code/TITLE31A/TITLE31A.htm>

Purposes (31A-1-102)

This section was based on information from the web site:

<http://www.le.state.ut.us/~code/TITLE31A/htm/31A01003.htm>

The **Utah Insurance Code** is known as **Title 31A** and consists of laws enacted by the Utah State Legislature. The purposes of the Insurance Code are to:

- (1) Ensure the solidity of insurers doing business in Utah;
- (2) Ensure that policyholders, claimants, and insurers are treated fairly and equitably;
- (3) Ensure that Utah has an adequate and healthy insurance market, characterized by competitive conditions, the spirit of innovation, and the exercise of initiative;
- (4) Provide for an insurance department that is expert in the field of insurance and able to enforce the Insurance Code effectively;
- (5) Encourage cooperation between the Insurance Department and other Utah regulatory bodies, as well as other federal and state governmental entities;
- (6) Preserve and improve state regulation of insurance;
- (7) Maintain freedom of contract and enterprise;
- (8) Encourage self regulation of the insurance industry;
- (9) Encourage loss prevention as part of the insurance industry;
- (10) Keep the public informed on insurance matters; and
- (11) Achieve other purposes stated elsewhere in the Insurance Code.

Use of Social Security Number (31A-21-110)

This section was based on information from the web site:

<http://www.le.state.ut.us/~code/TITLE31A/htm/31A15011.htm>

As used in this section "publicly display or publicly post" means to intentionally communicate or otherwise make available to the general public.

An insurer not subject to Section 31A-22-634 may not do any of the following: (a) publicly display or publicly post in any manner an individual's Social Security number; or (b) print an individual's Social Security number on any card required for the individual to access products or services provided or covered by the insurer.

This section does not prevent: (a) the collection, use, or release of a Social Security number as required by state or federal law; (b) the use of a Social Security number for internal verification or administrative purposes; or (c) the release of a Social Security number for claims administration purposes or as part of the verification, eligibility, or payment process.

Revocation or Suspension of License (31A-23a-111)

This section was based on information from the web site:

<http://www.le.state.ut.us/~code/TITLE31A/htm/31A17012.htm>

A license type issued under this chapter remains in force until revoked, suspended, surrendered, lapsed, or the licensee dies or is adjudicated incompetent.

A line of authority issued under this chapter remains in force until: (a) the qualifications pertaining to a line of authority are no longer met by the licensee; or (b) the supporting license type is revoked, suspended, or voluntarily surrendered.

If the commissioner makes a finding after an adjudicative proceeding, the Commissioner may: revoke, suspend, or limit a license or a line of authority. The commissioner may take an action described above if the commissioner finds that the licensee:

- 1) Is unqualified for a license or line of authority;
- 2) Has violated an insurance statute, rule, or order;
- 3) Is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;
- 4) Fails to pay any final judgment rendered against the person in this state within 60 days after the day the judgment became final;
- 5) Fails to meet the same good faith obligations in claims settlement that is

- required of admitted insurers;
- 6) Is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;
 - 7) Refuses to be examined or to produce its accounts, records, and files for examination;
 - 8) Has an officer who refuses to give information with respect to the administrator's affairs or perform any other legal obligation as to an examination;
 - 9) Provides information in the license application that is incorrect, misleading, incomplete, or materially untrue;
 - 10) Has violated any insurance law, valid rule, or valid order of another state's insurance department;
 - 11) Has obtained or attempted to obtain a license through misrepresentation or fraud;
 - 12) Has improperly withheld, misappropriated, or converted any monies or properties received in the course of doing insurance business;
 - 13) Has intentionally misrepresented the terms of an actual or proposed insurance contract or application for insurance;
 - 14) Has been convicted of a felony;
 - 15) Has admitted or been found to have committed any insurance unfair trade practice or fraud;
 - 16) In the conduct of business in this state or elsewhere has used fraudulent, coercive, or dishonest practices; or demonstrated incompetence, untrustworthiness, or financial irresponsibility;
 - 17) Has had an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;
 - 18) Has forged another's name to an application for insurance or any document related to an insurance transaction;
 - 19) Has improperly used notes or any other reference material to complete an examination for an insurance license;
 - 20) Has knowingly accepted insurance business from an individual who is not licensed;

- 21) Has failed to comply with an administrative or court order imposing a child support obligation;
- 22) Has failed to pay state income tax; or comply with any administrative or court order directing payment of state income tax;
- 23) Has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or
- 24) Has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.

An order revoking a license may specify a time, not to exceed five years, within which the former licensee may not apply for a new license. If no time is specified in an order revoking a license the former licensee may not apply for a new license for five years without express approval by the commissioner.

Continuing Education Requirement (31A-23a-202)

This section was based on information from the web site:

<http://www.le.utah.gov/~code/TITLE31A/htm/31A18020.htm>

Pursuant to this section, the commissioner shall by rule prescribe the continuing education requirements for a producer and a consultant.

The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements. Except as provided in this section, the continuing education requirements shall require:

- 1) That a licensee complete 24 credit hours of continuing education for every two-year licensing period;
- 2) That three of the 24 credit hours be ethics courses;
- 3) And that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

The hours not completed through classroom hours may be obtained through:

- 1) Home study;
- 2) Video recording;
- 3) Experience credit; or

4) Other methods provided by rule.

A licensee may obtain continuing education hours at any time during the two-year licensing period.

Beginning May 3, 1999, a licensee is exempt from continuing education requirements under this section if:

- 1) The licensee was first licensed before April 1, 1970;
- 2) The licensee requests an exemption from the department; and
- 3) The department approves the exemption.

The requirements of this section apply only to producers or consultants who are natural persons.

A nonresident producer or consultant is considered to have satisfied this state's continuing education requirements if the nonresident producer or consultant satisfies the nonresident producer's or consultant's home state's continuing education requirements for a licensed insurance producer or consultant.

A producer or consultant subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education applies.

Trust Obligation for Funds Collected (31A-23a-409)

This section was based on information from the web site:

<http://www.le.state.ut.us/~code/TITLE31A/htm/31A17036.htm>

Every licensee is a trustee for all funds received or collected for forwarding to insurers or to insureds.

Except for amounts necessary to pay bank charges, and except for funds paid by insureds and belonging in part to the licensee as fees or commissions, a licensee may not commingle trust funds with the licensee's own funds or funds held in any other capacity.

Every licensee owes to insureds and insurers the fiduciary duties of a trustee with respect to money to be forwarded to insurers or insureds through the licensee.

Unless the funds are sent to the appropriate payee by the close of the next business day after their receipt, the licensee shall deposit them in a trust

account. Funds deposited shall remain in the trust account until sent to the appropriate payee.

Funds required to be deposited shall be deposited: (a) in a federally insured trust account in a depository institution, which has an office in this state, has federal deposit insurance, and is authorized by its primary regulator to engage in the trust business; or (b) in some other account, approved by the commissioner by rule or order, providing safety comparable to federally insured trust accounts.

It is not a violation if the amounts in the accounts exceed the amount of the federal insurance on the accounts.

A trust account into which funds are deposited may be interest bearing. The interest accrued on the account may be paid to the licensee, so long as the licensee otherwise complies with this section and with the contract with the insurer.

A financial institution or other organization holding trust funds under this section may not offset or impound trust account funds against debts and obligations incurred by the licensee.

Any licensee who, not being lawfully entitled thereto, diverts or appropriates any portion of the funds to the licensee's own use, is guilty of theft.

Premium Received Forwarded (31A-23a-411.1)

This section was based on information from the web site:

<http://www.le.state.ut.us/~code/TITLE31A/htm/31A17038.htm>

A person commits insurance fraud if that person knowingly fails to forward to the insurer a premium:

- 1) Received from one of the following in partial or total payment of the premium due from an applicant, a policyholder, or a certificate holder; or
- 2) Collected from or on behalf of an insured employee under an insured employee benefit plan.

Business Address and Records (31A-23a-412)

This section was based on information from the web site:

<http://www.le.state.ut.us/~code/TITLE31A/htm/31A17039.htm>

All licensees under this chapter shall register with the commissioner the address

and telephone numbers of their principal place of business. If the licensee is an individual, the individual shall also provide to the commissioner the individual's residence address and telephone number. A licensee shall notify the commissioner within 30 days of any change of address or telephone number.

Every licensee under this chapter shall keep at the principal place of business address, separate and distinct books and records of all transactions consummated under the Utah license.

The books and records shall: (i) be in an organized form; (ii) be available to the commissioner for inspection upon reasonable notice; and (iii) include all of the following:

- 1) If the licensee is a producer, limited line producer, consultant, managing general agent, or reinsurance intermediary:
 - a. A record of each insurance contract procured by or issued through the licensee, with the names of insurers and insureds, the amount of premium and commissions or other compensation, and the subject of the insurance;
 - b. The names of any other producers, limited line producers, consultants, managing general agents, or reinsurance intermediaries from whom business is accepted, and of persons to whom commissions or allowances of any kind are promised or paid; and
 - c. A record of all consumer complaints forwarded to the licensee by an insurance regulator;
- 2) If the licensee is a consultant, a record of each agreement outlining the work performed and the fee for the work; and
- 3) Any additional information which:
 - a. Is customary for a similar business; or
 - b. May reasonably be required by the commissioner by rule.

The above requirements are satisfied if the books and records can be obtained immediately from a central storage place or elsewhere by on-line computer terminals located at the registered address.

A licensee who represents only a single insurer satisfies the above requirements if the insurer maintains the books and records at the registered address.

The books and records maintained shall be available for the inspection of the commissioner during all business hours for a period of time after the date of the transaction as specified by the commissioner by rule, but in no case for less than

the current calendar year plus three years. Discarding books and records after the applicable record retention period has expired does not place the licensee in violation of a later-adopted longer record retention period.

Fraudulent Insurance Act (31A-31-103)

This section was based on information from the web site:

<http://www.le.state.ut.us/~code/TITLE31A/htm/31A1E004.htm>

A person commits a fraudulent insurance act if that person with intent to deceive or defraud:

- 1) Knowingly presents or causes to be presented to an insurer any oral or written statement or representation knowing that the statement or representation contains false, incomplete, or misleading information concerning any fact material to an application for the issuance or renewal of an insurance policy, certificate, or contract;
- 2) Knowingly presents or causes to be presented to an insurer any oral or written statement or representation: as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, certificate, or contract; or in connection with any civil claim asserted for recovery of damages for personal or bodily injuries or property damage; and knowing that the statement or representation contains false, incomplete, or misleading information concerning any fact or thing material to the claim;
- 3) Knowingly accepts a benefit from the proceeds derived from a fraudulent insurance act;
- 4) Assists, abets, solicits, or conspires with another to commit a fraudulent insurance act;
- 5) Knowingly supplies false or fraudulent material information in any document or statement required by the department;
- 6) Knowingly fails to forward a premium to an insurer in violation of Section 31A-23a-411.1; or
- 7) Knowingly employs, uses, or acts as a runner for the purpose of committing a fraudulent insurance act.

5—Utah Insurance Rules

Only a small number of the many Utah Insurance Rules are presented in this course. For a complete listing, visit:

<http://www.insurance.state.ut.us/rules/index.htm>

Introduction

The **Utah Insurance Rules** are developed and issued by the Utah Insurance Department to implement or interpret the **Utah Insurance Code** and federal mandates. The rules have the same significance and effect as law.

Advertisements of Insurance (R590-130)

This section was based on information from the web site:

<http://www.rules.utah.gov/publicat/code/r590/r590-130.htm>

R590-130-6—Form and Content of Advertisements

- A. The format and content of an insurance advertisement shall be sufficiently complete and clear to avoid deceiving or misleading the reader, viewer, or listener. Whether an advertisement is misleading or deceiving shall be determined from the overall impression that the advertisement may reasonably be expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.
- B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, may not be used without a clear explanation of such words or phrases.
- C. An insurer must clearly identify its insurance policy as an insurance policy. A policy trade name must be followed by the words "Insurance Policy" or similar words clearly identifying the fact that an insurance policy or, in the case of health maintenance organizations, prepaid health plans and other direct service organizations, a health benefits product is being offered.
- D. No insurer, agent, broker, producer, solicitor or other person may solicit residents of this state for the purchase of insurance through the use of a name that is deceptive or misleading with regard to the status, character, or proprietary or representative capacity of such person, or the true purpose of the advertisement.

R590-130-9—Testimonials or Endorsements by Third Parties

A. A person shall be deemed a "spokesperson" if the person making the testimonial or endorsement:

- (1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise; or
- (2) Has been formed by the insurer, is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer; or
- (3) Has any person in a policy making position who is affiliated with the insurer in any of the above described capacities; or
- (4) Is in any way directly or indirectly compensated for making a testimonial or endorsement.

B. The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence thereto. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." The requirement of this disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of non-print advertising, the required disclosure must be accomplished in the introductory portion of the advertisement and must be given prominence.

C. An advertisement may not state or imply that an insurer or an insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy making position in the association, that fact must be disclosed.

D. When a testimonial refers to benefits received under an insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of three years after the last use of said testimonial in any advertisement. The use of testimonials which do not correctly reflect the present practices of the insurer or which are not applicable to the policy or benefit being advertised is prohibited.

E. An advertisement may not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of any state or federal government. "Approval" or filing of either policy forms or advertising may not be used by an insurer to state or imply that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition.

R590-130-10—Use of Statistics and Exaggerations

A. An advertisement may not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim under the policy advertised is misleading and may not be used.

B. The source of any statistics used in an advertisement shall be identified in such advertisement.

R590-130-11—Identification of Plan or Number of Policies

A. When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

B. When an advertisement which is an invitation to contract refers to various benefits which may be obtained only through two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

R590-130-12—Identity of Insurer

A. The name of the actual insurer shall be stated in all advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement which is an invitation to contract. An advertisement may not use a trade name, any insurance group designation, name of a parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device without disclosing the name of the actual insurer if the advertisement would be misleading or deceiving as to the true identity of the insurer.

B. No advertisement may use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of any state, or otherwise appear to be of such a nature that it would confuse or mislead prospective insureds into believing that the solicitation is in some manner

connected with an agency of any municipal, state or federal government.

C. Advertisements, envelopes or stationery which employ words, letters, initials, symbols or other devices which are so similar to those used in governmental agencies or by other insurers are not permitted if they may lead the public to believe:

(1) That the advertised coverages are somehow provided by or are endorsed by a governmental agency or such other insurers.

(2) That the advertiser is the same as, is connected with, or is endorsed by a governmental agency or such other insurers.

D. No advertisement may use the name of a state or political subdivision thereof in a policy name or description, unless the company name contains the same state or political subdivision name.

E. No advertisement in the form of envelopes or stationery of any kind may use any name, service mark, slogan, symbol or any device in such a manner that implies that the insurer or the policy advertised, or any agent who may call upon the consumer in response to the advertisement is connected with a governmental agency, such as the Social Security Administration.

F. No advertisement may incorporate the word "Medicare" in the title of the plan or policy being advertised unless, where ever it appears, said word is qualified by language differentiating it from Medicare. Such an advertisement, however, may not use the phrase "() Medicare Department of the () Insurance Company," or language of similar import.

G. No advertisement may imply that the reader may lose a right or privilege or benefit under federal, state or local law if he fails to respond to the advertisement.

H. The use of letters, initials, or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters initials or symbols of the corporate name or trademark.

I. The use of the name of an agency or "() Underwriters" or "() Plan" in type, size and location so as to mislead or deceive as to the true identity of the insurer or advertiser is prohibited.

J. The use of an address that is misleading or deceiving as to the true identity of the insurer or advertiser, its location or licensing status is prohibited.

K. No insurer or advertiser may use, in the trade name of its insurance policy,

any terminology or words so similar to the name of a governmental agency or governmental program that will confuse, deceive or mislead the prospective purchaser regarding governmental sponsorship, endorsement, or connection with the insurance policy or the insurer.

R590-130-13—Group or Quasi-Group Implications

A. An advertisement of a particular policy may not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact and renewal rates are also given special or preferred status.

B. This rule prohibits the solicitations of a particular class such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

R590-130-14—Enforcement Procedures

Advertising File. Each insurer or advertiser shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodic inspection by this Department. All such advertisements shall be maintained in said file for a period of three years from date of last use.

Unfair Marketing Practices (R590-154)

This section was based on information from the web site:

<http://www.rules.utah.gov/publicat/code/r590/r590-154.htm>

R590-154-3—Definitions

A. "Agency" means:

1. A person other than an individual, including a sole proprietorship by which a natural person does business under an assumed name; and
2. An insurance organization licensed or required to be licensed under Section 31A-23-212(3).

B. "Barter" means the sale of an insurance or annuity contract for anything of

value other than cash or other negotiable instruments.

C. "Producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance. With regards to the selling, soliciting, or negotiating of an insurance product to an insurance customer or an insured:

1. "Producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating any product of that insurer.
2. "Producer for the insured" means a producer who is compensated directly and only by an insurance customer or an insured and receives no compensation directly or indirectly from an insurer for selling, soliciting, or negotiating any product of that insurer to that insurance customer or insured.

R590-154-4—Findings

The commissioner finds that each of the practices prohibited in this rule constitute misleading, deceptive or unfairly discriminatory practices or provide an unfair inducement or unreasonably restrain competition, except as specifically allowed in this rule.

R590-154-5—Producer, Limited Lines Producer or Consultant Agency Name

A. An insurance producer, limited lines producer or consultant agency licensed under the laws of this state shall not use any name that is:

- (1) Misleading or deceptive;
- (2) Likely to be mistaken for another licensee already in business; or
- (3) Implies association or connection with any other organization where actual bona fide association or connection does not exist.

B. A producer, limited line producer or consultant agency licensee shall comply with either of the following:

1. The agency shall include words such as "insurance agency" or "insurance consultant" or other similar words in the agency's name.
 - (a) Other similar words such as "insurance services", "insurance benefits", "insurance counselors", or "insurance advisors" may also be used.
 - (b) "Insurance consulting," "insurance consultants" or similar words shall only be used if the agency is licensed as a consultant.
2. The agency shall state that the licensee is an insurance agency in any

letterhead, business cards, advertising, slogan, emblem, or other promotional material used or distributed by the agency in the State of Utah.

R590-154-6—Individual Licensee Name

- A. An individual shall be licensed using the individual's full legal name - first name or initial, middle name or initial, last name, suffix, jr/sr/II/III/etc.
- B. An individual may file with the department a preferred name or nickname to use in combination with the individual's full legal name.

R590-154-7—Sale, Solicitation, or Negotiation of Insurance

A. An individual licensee and a producer, limited line producer or consultant agency licensee shall not mislead or deceive a person or organization through oral contact or through any letterhead, business cards, advertising, slogan, emblem, or other promotional material used or distributed in Utah by:

1. Failing to disclose that the licensee is an individual insurance licensee or a producer, limited line producer or consultant agency licensee in every oral or written contact; or
2. Using or implying license classifications not held by the individual licensee or natural persons designated to the producer, limited line producer or consultant agency licensee; or
3. Using a name other than the exact name appearing on the producer, limited line producer or consultant agency license; or
4. Using a name other than the individual licensee's full legal name exactly as filed with the department; or
5. Using an individual's preferred name or nickname when the preferred name or nickname has not been filed with the department; and

B. The use of an initial letter, rather than the full first or middle name is not a violation of this section.

C. An individual may only use the name of a producer, limited line producer or consultant agency that has its own separate agency license if the individual licensee is designated to act under that agency's license.

D. An individual may not sell, solicit, or negotiate insurance as a producer, limited line producer or consultant agency unless the individual has a separate producer, limited line producer or consultant agency license and the individual is designated to act under the agency's license.

R590-154-8—Claiming or Representing Department Approval

A. A licensee may not represent, either directly or indirectly, that the Utah Insurance Department, the insurance commissioner, or any employee of the department, has approved, reviewed, endorsed, or in any way favorably passed upon any marketing program, insurance product, insurance company, practice or act.

B. A licensee may report the fact of the filing of any form, financial report, or other document with the Insurance Department, or of licensure, examination or other action involving the department, or the commissioner but may not misrepresent their effect or import.

R590-154-9—Bartering for Insurance

Any licensee bartering for the sale of insurance or an annuity contract shall fully document the receipt of goods, services or other thing of value, establishing the value of the thing received and how the value was established, from whom received, the date received, and the premium cost of the insurance or annuity contract bartered for, and shall retain said documentation for three years following the expiration of the policy period or bartering transaction, whichever is longer. Any licensee bartering for the sale of an insurance or annuity contract shall disclose at the time of application to the insurer said bartering arrangement.

R590-154-10—Prohibited Insurance Sales Tie-Ins

Multi-level marketing programs, investment programs, memberships, or other similar programs, designed or represented to produce or provide funds to pay all or any part of the cost of insurance constitutes an illegal inducement. This does not preclude the provision of insurance through a bona fide employee benefits program.

R590-154-11—Inducements, Gifts and Merchandise Given in Connection With Solicitation or Sale of Insurance

A. A licensee may not give or offer to give any prizes, goods, wares, merchandise or item of value as an inducement to enter into any insurance or annuity contract or as an inducement to receive a quote, submit an application or in connection with any other solicitation for the sale of an insurance or annuity contract. However, anything with an acquisition cost of \$3.00 or less shall not be considered an inducement.

B. Subsection A of this section does not prohibit the giving of promotional gifts or merchandise that is generally available to the public and not given in a manner to constitute an inducement to receive a quote or other solicitation or to purchase any insurance or annuity contract, nor does it prohibit insurers from providing sales incentives to producers.

C. This section does not prohibit the usual kinds of social courtesies as long as they are not related to a particular transaction as stated in Subsection 31A-23-302(2)(a). If the receiving of the social courtesy is dependant on obtaining a quote, submitting an application or purchasing a policy or contract, it is related to a particular transaction.

D. This section does not apply to title insurers or agents. Rule R590-153 is the applicable rule for the marketing of title insurance.

R590-154-12—Commission Contributions

A licensee shall not give or offer to give a premium reduction by means of commission contribution back to the insurer for any purpose, including competition, unless the reduction is for expense savings and is justified by a reasonable standard and with reasonable accuracy. The insurer's underwriting files must document the savings in order to enable the commissioner to verify compliance. This documentation must demonstrate legitimate expense savings realized by the insurer and its agent.

R590-154-13—Prohibited Financing Arrangements

A licensee may not obtain or arrange for third party financing of premium without the knowledge and consent of the insured.

R590-154-14—Acting as Individual or Agency Licensee in Other Jurisdictions

An individual or agency licensee licensed in the State of Utah under a resident license, may not sell, solicit, or negotiate insurance in another jurisdiction unless licensed or permitted by law to do so in that jurisdiction.

R590-154-15—Use of Comparative Information

A. Every insurer marketing insurance in the State of Utah shall establish written marketing procedures to assure that any comparison of insurance contracts, annuities or insurance companies by its producers will be fair and accurate.

B. A licensee may not use any published rating information regarding an insurer in connection with the marketing of any insurance contract or annuity unless that person also provides at the same time an explanation of what the rating means as defined by the rating service.

R590-154-16—Disclosure of Insurer in Group Insurance

Every certificate of insurance or booklet describing coverage of a group insurance policy shall prominently state on the cover of the certificate or booklet the name of the actual insurer.

Fiduciary and Trust Account Obligations (R590-170)

This section was based on information from the web site:

<http://www.rules.utah.gov/publicat/code/r590/r590-170.htm>

R590-170-3—Definitions

For the purposes of this rule the commissioner adopts the definitions as set forth:

- (1) "Trust Account" means a checking or savings account where funds are held in a fiduciary capacity.
- (2) "Accounts Receivable" means premiums, fees, or taxes invoiced by a licensee.
- (3) "Accounts Payable" means premiums or fees due insurers that a licensee is responsible for invoicing and collecting from insureds on behalf of insurers and licensees and premium taxes due taxing entities.
- (4) "Licensee" means a licensee under Chapters 31A-23a and 31A-25.

R590-170-4—Establishing the Trust Account

- (1) All records relating to a trust account shall be identified with the wording "Trust Account" or words of similar import. These records include checks, bank statements, general ledgers and records retained by the bank pertaining to the trust account.
- (2) All trust accounts shall be established with a Federal Employer Identification Number rather than a Social Security Number.
- (3) A trust account shall be separate and distinct from operating and personal accounts, i.e., a separate account number, a separate account register, and different checks, deposit and withdrawal slips.
- (4) A non-licensee may not be a signator on a licensee's trust account, unless the non-licensee signatory is an employee of the licensee and has specific responsibility for the licensee's trust account.

R590-170-5—Maintaining the Trust Account

- (1) Funds deposited into a trust account shall be limited to: premiums which may include commissions; return premiums; fees or taxes paid with premiums; financed premiums; funds held pursuant to a third party administrator contract; funds deposited with a title insurance agent in connection with any escrow settlement or closing, amounts necessary to cover bank charges on the trust account; and interest on the trust account, except as provided.

- (2) Disbursements from a trust account shall be limited to: premiums paid to insurers; return premiums to policyholders; transfer of commissions and fees; fees or taxes collected with premiums paid to insurers or taxing authority; funds paid pursuant to a third party administrator contract; funds disbursed by a title insurance agent in connection with any escrow settlement or closing; and the transfer of accrued interest.
- (3) Personal or business expenses may not be paid from a trust account, even if sufficient commissions exist in the account to cover these expenses.
- (4) Commissions may not be disbursed from a trust account prior to the beginning of the policy period for which the premium has been collected.
- (5) Commissions attributed to premiums and fees collected must be disbursed from a trust account on a date not later than the first business day of the calendar quarter after the end of the policy period for which the funds were collected.
- (6) Premiums due insurers may not be paid from a trust account unless the premiums directly relating to the amount due have been deposited into, and are being held in, the trust account, or unless funds have been retained in the trust account consistent with Subsection 5 above, or placed by a licensee into the trust account to finance premiums on behalf of insureds.
- (7) Premiums financed by a licensee must be accounted for as a loan with interest charged at no less than the statutory rate for any loan exceeding 90 days.

R590-170-6—Insurers' Access to Trust Accounts

- (1) Insurer access to licensee trust funds is not prohibited by the trust relationship; however, licensees must take reasonable steps to assure trust funds are protected from misappropriation by limiting access to those trust funds.
- (2) An insurer desiring to access funds in a licensee's trust account may do so if:
 - (a) The contract between the insurer and the licensee allows electronic fund transfers into or out of the licensee's trust account:
 - (i) Expressly permits the insurer to withdraw only the amount authorized by the licensee for each transaction; and
 - (ii) Specific authorization from the licensee of the amount to be withdrawn from the licensee's trust account must be received by the insurer prior to the withdrawal; or
 - (b) The licensee provides the insurer electronic funds transfer into or out of a separate trust account set up solely for trust funds deposited for that insurer.

(3) By implementing electronic funds transfers from a licensee's trust account, the insurer accepts the commissioner's right to oversight of all electronic funds transfers between the insurer and licensee.

(4) Insurers utilizing electronic funds transfer contracts will annually report to the commissioner the name of each licensee with whom they have such contracts.

(a) The report is due January 15 of each year.

(b) The report will include the name and address of each licensee and the line of business involved, i.e. personal lines, commercial lines, health, life, etc.

R590-170-7—Accounting Records to be Maintained

(1) Bank statements for trust accounts shall be reconciled monthly.

(2) An accounts receivable report showing credits and debits shall be maintained and reconciled monthly. This report must list, at a minimum, the account name and the amount and date due for each receivable. The sum of all receivables shall be shown on the report. Receivables and their sums that are over 90 days old shall be shown separately on the report.

(3) An accounts payable report showing the status of each account shall be maintained and reconciled monthly.

(4) Adequate records shall be maintained to establish ownership of all funds in the trust account: from whom they were received; and for whom they are held.

(5) Trust account registers shall maintain a running balance.

(6) All accounting records relating to the business of insurance shall be maintained in a manner that facilitates an audit.

R590-170-8—Insurer Responsibility

Insurers and their managing general agents shall provide a written report to the insurance commissioner within 15 days:

(1) If a licensee fails to pay an account payable within 30 days of the due date. This does not apply where a legitimate dispute exists regarding the account payable if the licensee has properly notified the insurer of any disputed items and has provided documentation supporting that position; or

(2) If a licensee issues a check that when presented at the bank is not honored or is returned because of insufficient funds.