

Chapter I

General Insurance Principles

What is Insurance?

Insurance is a method of handling pure risk by spreading it over a large number of homogeneous (similar) exposure units to predict individual losses with some accuracy. This is the more formal definition of insurance that state testing vendors want you to know. There is, however, another term used by the insurance industry that you need to know and understand. That term is **indemnity**. Insurance contracts are contracts of indemnity: their purpose is to reimburse an insured for a covered loss, thereby restoring the insured to the financial position that he/she enjoyed prior to the loss. To indemnify means to compensate or reimburse, and is the purpose of insurance.

With life insurance, the principle of indemnity is interpreted liberally. The life insurance contract “reimburses” a beneficiary for the stated amount of the policy upon the death of the insured. The face amount of the policy represents a predetermined value of an individual’s life for a given situation or purpose such as creation of an estate, payment of a mortgage, etc.

Insurance, as you are learning, is about **risk**, and insurable risk has been defined as an uncertainty concerning financial loss. There are two types of risk:

1. **Speculative Risks** - involve the possibility of both gain and loss, such as investing in the stock market. Speculative risks are common to business.
2. **Pure Risks** - involve only the possibility of loss: gain is never possible. For example, loss of a building to fire is a pure risk. Similarly, loss of a wage earner to premature death is another example of a pure risk. With pure risk, the end result is a constant known fact. A loss will occur.

Pure risks are insurable; speculative risks are not.

Peril vs. Hazard

Peril is the actual **cause** of a loss (such as a heart attack). **Hazard** is any condition (such as smoking) that **increases** the possibility of a loss or peril. The underlying cause of a loss may result from physical hazards or moral hazards.

Note: You must know the difference between peril and hazard.

To control the level of risk it assumes, insurance companies are concerned about hazards that increase the likelihood that a peril will strike or increases the potential severity of the loss.

- Physical Hazards - tangible circumstances such as a heart condition or a high-risk hobby that might cause a company to decline a risk.
- Moral Hazards - are intentional losses, such as fraudulent claims, which companies try to screen out with probationary periods, exclusions and other underwriting devices.

- **Morale Hazards** - occur when an insured ignores the financial impact of a loss because the company pays for it. Companies control this hazard with deductibles, coinsurance and other policy limitations.

The Law of Large Numbers

For the insurance company to make money, it must not only know how much it is on the hook for, it must know how much risk it is accepting. What is the chance of loss? If an insurance company issues a policy on 40-year-old John Insured, a non-smoking male in a low risk occupation who is in excellent physical shape, the company has absolutely no idea when John will die. He could die tomorrow, he could die at age 72, or he could live to be 102. It is impossible to accurately predict what will happen to one particular person. However, the Law of Large Numbers says that what will happen to a large group of similar individuals (or homogeneous exposure units) is very predictable. If the company insured John along with 100,000 other 40-year-old males who were in similar condition, the men would have an average life expectancy of another 32 years. Some would die earlier than expected and the company would lose by paying a death benefit after collecting only a few premiums. Most would die on schedule, and the company would pay as it expected. A few would live much longer than anticipated and the company would win by paying death claims much later than expected. Overall, the company would profit. Using these concepts, the question now becomes, how do we transfer risk?

Although it is simple to say that most people prefer to transfer their risk of economic death to an insurance company, a little thought is required to understand exactly how it is done. The basic concept is not that difficult. Many insurance historians trace the basic concept of insurance back many centuries to the Chinese. In a principally agrarian society, Chinese farmers were faced with the problem of getting their crops to market. Most of them simply loaded their crops on a boat and used the rivers as transportation. Occasionally though, a boat would overturn and an entire harvest would be lost. The farmers began to transfer this risk to other farmers in a brilliantly simple way. Ten farmers from one area would get together at harvest and load the boats by putting one-tenth of every farmer's crop on each boat. If a boat sunk, each farmer lost a little, but no one lost everything.

This concept of sharing risk is the basis of all insurance products. A modern-day policyowner trades a small known loss (premium) for the insurance company's promise to pay for a large, unknown loss should it occur. All of the policyowners lose a little, but no one has to take the risk of losing everything.

A slightly more traditional definition would say that insurance is a device that provides for the transfer of individual risk to a company which, for consideration, assumes losses suffered by the insured to a predetermined limit.

Insurable Interest

An individual has an insurable interest in some person or object when the death or injury of the person or damage or destruction of the object results in financial loss to the individual.

In property and casualty insurance, the insurable interest must be present at the time of the loss. An individual would have an insurable interest in a house if he/she owned all or part of it. The bank holding the mortgage in this house would have an insurable interest in it because damage or destruction to it could result in financial loss to the bank. In contrast, the citizens of a community might have a sentimental interest in an old structure located in town because of its historical importance. Unless they owned some portion of it, they could not obtain insurance on it because, by definition, they have no insurable interest in it.

With life insurance, the insurable interest must exist at the inception of the policy, but not necessarily at the time of loss. A husband has an insurable interest in his wife's life; the wife has an insurable interest in her husband's life. But relationships change. An individual may retain a life insurance policy on his/her spouse even though the couple is separated or divorced: insurable interest existed at the inception of the policy. In some cases, new life insurance

must be written on one or both parties in a divorce settlement as a condition of the settlement. The untimely death of one of the parties would affect the economic well being of the other adversely, contrary to the terms of a given divorce decree.

Individuals have an unlimited insurable interest in themselves. Most jurisdictions acknowledge the insurable interest of parent and child, and some of brother and sister and grandparent and grandchild. The insurable interest of other family relationships must be demonstrated on an individual basis.

Finally, individuals involved in a business partnership or creditors in a debtor-creditor relationship are seen to have an insurable interest in the lives of their partners or debtors respectively. Why? The untimely death of the partner or debtor would create an economic hardship on the other party.

In summary, insurable interest in life insurance must exist at the time of applying for coverage. An individual (or organization) has an insurable interest in the life of another individual if the death of the latter brings financial loss to the former or creates an adverse impact on the former by virtue of their relationship (spouse, child, etc.).

Reinsurance

“Reinsurance” is insurance for insurers. Through reinsurance, one insurance company (ceding insurer) reduces its exposure by transferring (ceding) some or all of its business to another insurer (the assuming insurer). **The assuming insurer is also known as the reinsurer.** When business is reinsured on a risk-by-risk basis, it is called “facultative reinsurance”. When business is reinsured on a regular percentage basis, it is called “treaty reinsurance”. Reinsurance allows one insurer to write a very large risk and then cede as much of the risk as needed. Without this capacity to write larger risks, some insurers would never be able to grow. Reinsurance is a transaction between insurance companies. If you were to think about the property damage and destruction of the World Trade Center, you can see that if those properties had not been reinsured, but insured by only one insurance company, that loss would have been financially devastating to that insurer.

Underwriting – What is It?

In a few words, underwriting is a risk assessment process by an insurance company to determine if the risk being considered meets the insurer’s acceptable standards. In other words, underwriting is the process by which prospective insureds are reviewed or examined for their acceptability as insureds. Prospects are either accepted or rejected as a result of the underwriting process. Accepted risks are classified as to their potential for loss – preferred, standard or high risk. These classifications of risk are classifications you will need to know and understand.

The purpose of underwriting is to ensure an insurance company that it is pooling similar pure risks, not dissimilar ones. In this way, losses can be predicted with some accuracy and premiums can be determined accordingly.

The initial consideration in underwriting is the selection of acceptable risks. The end product of the underwriting process is the development of a company’s rate structure. The underwriting process demands adherence to certain guidelines or underwriting rules by which an insurer must abide in order to prevent the adverse selection of risks which have a greater than average exposure to loss. Adverse selection has a negative impact on an insurance company’s rates. The following are some life and health insurance underwriting criteria that is considered by the underwriter:

- Amount of insurance requested
- Financial condition
- Age of applicant
- Physical condition
- Medical background
- Personal habits
- Family health history
- Other insurance
- Purpose of insurance

The underwriting process depends on a particular insurer's underwriting philosophy as well as the specifics of the insurance policy under consideration. A physical examination may be required of the applicant, depending on the age of the applicant and the amount of insurance being applied for. There are constants in the underwriting process such as requesting and receiving medical reports from an applicant's attending physician. Such a report is known as an "attending physician's statement" and also referred to as an APS. Another constant in the underwriting process is a personal background report, usually referred to as an "inspection report." This report, usually provided by a background reporting agency such as Equifax, provides information about an applicant covering the past seven years of the individual's life. Inspection reports include information such as where the applicant resides, personal character of the applicant, drinking habits, driving record, employment record, etc. A report from the Medical Information Bureau (MIB) is another constant in the underwriting process. The MIB maintains medical information about persons who have applied for insurance and the underwriting determination made by the insurer being applied to. The MIB also records whether or not the policy was accepted by the applicant.

Once life underwriters have gathered information on a prospective insured's medical, character and credit background, they can classify these risks in one of the following categories:

- **Preferred** - Usually non-smokers/non-tobacco users with no health or occupational problems
- **Standard** – No health or occupational problems but may use tobacco products
- **High Risk** – Those with health problems, occupational hazards or avocation risks

Premium Determination

Since death is the eventual ending to life, life insurance policies are written with the assumption that they will be called upon to pay, in full, eventually. Since a life insurance contract anticipates the eventual payment of its policy limits, it also anticipates the development of a fund - known as a policy reserve - that will address this payment. Based on its mortality table and its use of the "law of large numbers" to predict numbers living and dying in a particular age group, a company can establish a rate for life insurance protection at each chronological age.

In addition to the actuarial basis of its mortality table, companies base the needs of their loss reserve funds on the basis of interest that they will make on the premiums which they collect and this interest will help defray the cost of future losses.

Finally, a loading factor is added to address the costs connected with the marketing, sale and administration of insurance. In summary, life insurance rate-making is based on three major factors:

- Mortality tables
- Interest income
- Loading factors

Combining the rate-making process with the classification process, we can understand that:

- Standard risks pay “standard rates” for their risk exposure to the company
- Preferred risks (e.g., non-smokers), pay “preferred rates” which are cheaper than standard rates
- High risks or substandard risks (e.g., overweight individuals), pay “substandard rates” which are more expensive than standard rates.

Mortality Tables

Mortality tables are based on the theory of probability based on the law of large numbers and are used in life insurance to predict the number of persons at a particular age who will live or die. The following are common factors of a mortality table:

- Information is provided from the age of “0” through age “99”
- Each mortality table begins with a population of 10,000,000 individuals and ends, after 99 years with a population of “0”.
- The information provided consists of:
 - The number of individuals living at any given age
 - The number of deaths each year
 - The number of deaths per 1,000 each year
 - The number of years of life expectancy for those alive at the end of the year in question

Please note the mortality table that follows. You will see that mortality rates increase annually. This point will help you to better understand the life insurance products in the following chapters.

Table of Mortality
COMMISSIONERS 1980 STANDARD ORDINARY

Age	Male Mortality Rate Per 1,000	Male Expectancy, Years	Female Mortality Rate Per 1,000	Female Expectancy, Years	Age	Male Mortality Rate Per 1,000	Male Expectancy, Years	Female Mortality Rate Per 1,000	Female Expectancy, Years
0	4.18	70.83	2.89	75.83	50	6.71	25.36	4.96	29.53
1	1.07	70.13	.87	75.04	51	7.30	24.52	5.31	28.67
2	.99	69.20	.81	74.11	52	7.96	23.70	5.70	27.82
3	.98	68.27	.79	73.11	53	8.71	22.89	6.15	26.98
4	.95	67.34	.77	72.23	54	9.56	22.08	6.61	26.14
5	.90	66.40	.76	71.28	55	10.47	21.29	7.09	25.31
6	.85	65.46	.73	70.34	56	11.46	20.51	7.57	24.49
7	.80	64.52	.72	69.39	57	12.49	19.74	8.03	23.67
8	.76	63.57	.70	68.44	58	13.59	18.99	8.47	22.86
9	.74	62.62	.69	67.48	59	14.77	18.24	8.94	22.05
10	.73	61.66	.68	66.53	60	16.08	17.51	9.47	21.25
11	.77	60.71	.69	65.58	61	17.54	16.79	10.13	20.44
12	.85	59.75	.72	64.62	62	19.19	16.08	10.96	19.65
13	.99	58.80	.75	63.67	63	21.06	15.38	12.02	18.86
14	1.15	57.86	.80	62.71	64	23.14	14.70	13.25	18.08
15	1.33	56.93	.85	61.72	65	25.42	14.04	14.59	17.32
16	1.51	56.00	.90	60.82	66	27.85	13.39	16.00	16.57
17	1.67	55.09	.95	59.87	67	30.44	12.76	17.43	15.83
18	1.78	54.18	.98	58.93	68	33.19	12.14	18.84	15.10
19	1.86	53.27	1.02	57.98	69	36.17	11.54	20.36	14.38
20	1.90	52.37	1.05	57.04	70	39.51	10.96	22.11	13.67
21	1.91	51.47	1.07	56.10	71	43.30	10.39	24.23	12.97
22	1.89	50.57	1.09	55.16	72	47.65	9.84	26.87	12.28
23	1.86	49.66	1.11	54.22	73	52.64	9.30	30.11	11.60
24	1.82	48.75	1.14	53.28	74	58.19	8.79	33.93	10.95
25	1.77	47.84	1.16	52.34	75	64.19	8.31	38.24	10.32
26	1.73	46.93	1.19	51.40	76	70.53	7.84	42.97	9.71
27	1.71	46.01	1.22	50.46	77	77.12	7.40	48.04	9.12
28	1.70	45.09	1.26	49.52	78	83.90	6.97	53.45	8.55
29	1.71	44.16	1.30	48.59	79	91.05	6.57	59.35	8.01
30	1.73	43.24	1.35	47.65	80	98.84	6.18	65.99	7.48
31	1.78	42.31	1.40	46.71	81	107.48	5.80	73.60	6.98
32	1.83	41.38	1.45	45.78	82	117.25	5.44	82.40	6.49
33	1.91	40.46	1.50	44.84	83	128.26	5.09	92.53	6.03
34	2.00	39.54	1.58	43.91	84	140.25	4.77	103.81	5.59
35	2.11	38.61	1.65	42.98	85	152.95	4.46	116.10	5.18
36	2.24	37.69	1.76	42.05	86	166.09	4.18	129.29	4.80
37	2.40	36.78	1.89	41.12	87	179.55	3.91	143.32	4.43
38	2.58	35.87	2.04	40.20	88	193.27	3.66	158.18	4.09
39	2.79	34.96	2.22	39.28	89	207.29	3.41	173.94	3.77
40	3.02	34.05	2.42	38.36	90	221.77	3.18	190.75	3.45
41	3.29	33.16	2.64	37.46	91	236.98	2.94	208.87	3.15
42	3.56	32.26	2.87	36.55	92	253.45	2.70	228.81	2.85
43	3.87	31.38	3.09	35.66	93	272.11	2.44	251.51	2.55
44	4.19	30.50	3.32	34.77	94	295.90	2.17	279.31	2.24
45	4.55	29.62	3.56	33.88	95	329.96	1.87	317.32	1.91
46	4.92	28.76	3.80	33.00	96	384.55	1.54	375.74	1.56
47	5.32	27.90	4.05	32.12	97	480.20	1.20	474.97	1.21
48	5.74	27.04	4.33	31.25	98	657.98	.84	655.85	.84
49	6.21	26.20	4.63	30.39	99	1000.00	.50	1000.00	.50

Based on experience of years 1970 - 1975

Important Concepts & Terms to Remember

Unilateral - After a premium is paid by the insured, only one party has an obligation to do anything further; that is of course, the insurance company. The contract becomes a “one-way contract” and continues in this form as long as premiums continue to be paid. This is a very important point. Once a life insurance policy has been issued, the obligations contained in the policy must be fulfilled by the insurance company. This is the case even though certain aspects in an insured’s life may change, i.e., the insured begins using tobacco products or becomes involved in hazardous activities such as skydiving, base jumping, etc. The insurance company is bound by terms of the insurance policy and cannot change the premium after the policy has been issued to the insured.

Aleatory - A mutual agreement of which the effects, with respect to the advantages and the losses, whether to all the parties or to some of them, depend on an uncertain event. These are contracts in which a promise by one party is conditioned on a fortuitous event. Another characteristic is that the values given by the parties are unequal: the insured - a premium; the insurer - future benefits.

Contract of Adhesion - The insurance company is the author of the contract and the insured must accept it “as is.” There is unequal bargaining strength between the parties; therefore, any ambiguous language will bring a court decision in favor of the insured.

Conditional Contract - Both parties must perform certain acts to make the contract legally enforceable. An insurance company’s obligation to pay under certain conditions of the contract is subject to the insured performing certain acts such as paying premiums, filing claims, etc.

Fraud – A generic term, embracing all multifarious means which human ingenuity can devise, and which are resorted to by one individual to get advantage over another by false suggestions or by suppression of truth, and includes all surprise, trick, cunning, dissembling, and any unfair way by which another is cheated.

Fiduciary - Being responsible for proper handling of money, keeping accurate records on behalf of the insurer, assisting in filing of claims and other necessary paperwork for the insured. The producer’s responsibility as a fiduciary is to both the insured and the insurer.

Estoppel - a legal bar to changing or denying a fact because of one’s own previous actions or words to the contrary. The doctrine of estoppel prevents one from changing his mind once committed to a course of action. As an example, once the incontestability clause and/or suicide clause have expired, the life insurer is prevented (estopped) from denying a claim for material misrepresentation, or the act of suicide. The Principal of “waiver” is usually combined with the doctrine of estoppel. The carrier, through the expiration of the incontestability clause and/or suicide clause, has “waived” the right of claim denial.

Malfeasance - A wrongful act which a person has no legal right to do, or any wrongful conduct which affect, interrupts, or interferes with performance of their official duty, or an act for which there is no authority; the unjust performance of some act, which party performing it has not right, or has contracted not to do.

Franchise Insurance - is a life insurance plan under which a number of individual term insurance policies are issued at special rates to a selected group. Usually used for groups too small to qualify for true group or in association group cases. Is sometimes referred to as “wholesale” insurance.

Types of Insurance Companies

Lloyd's of London

Probably the most startling fact about Lloyd's is that it is not an insurance company and does not issue policies. It merely provides a vehicle for associations of individuals to write insurance. The roots of this historically rich organization began in 17th century England when merchants gathered at the coffeehouses to do business and exchange ideas.

Today's Lloyd's functions much as it did originally. However, substantial financial requirements are now placed upon the underwriters who are organized into syndicates (associations) controlled by managing agents. Usually several of the over 250 Lloyd's syndicates are involved in underwriting a single risk. While the primary function of Lloyd's is to provide property and casualty coverage for normal exposures, it is most famous for underwriting highly unusual, one-of-a-kind risks.

Lloyd's most important contribution to our industry today is probably its ability to reinsure insurance companies around the world, thus spreading the risk and providing additional insuring capacity. In the same way an individual can transfer risk to an insurance company, that company may transfer some of its risk to still another insurance company. As we have discussed, this process is known as reinsurance.

Stock Companies

A stock life company is a corporation that is organized to conduct the business of life insurance and is actually owned by its stockholders or shareholders. Shares of stock are sold to the stockholders to provide the capital (money) which the corporation needs in order to get started. This capital sustains the organization until it makes enough money to operate from current income. Since the stockholders own the company, they are entitled to share in the company profits, which are paid to them as a dividend - a return on their capital investment. On the other hand, individuals who have purchased insurance from the company, called policyowners, do not participate in company profits and never receive dividends as they have no capital investment in the company. In short, a stock company may be characterized by the fact that:

- It is operated for the ultimate benefit of the stockholders.
- A portion of the earnings is paid to stockholders as dividends.
- The board of directors of the company is elected by the stockholders.
- It does not pay dividends to its policyowners. The policyowners do not participate in company profits, and stock companies are therefore referred to as **non-participating companies**.

Mutual Companies

The most important legal difference between a mutual company and a stock company is that a mutual has no stockholders and exists, therefore, for the benefit of the policyowners. Because it has no stockholders, a mutual must be started in a different manner. The first step for a new mutual company is to find a required number of

individuals willing to purchase a minimum amount of insurance from the company. Since most people would be reluctant to apply for insurance from a company that could only be formed if enough applications are taken in advance, it is almost impossible to start a mutual today. Most mutuals are now formed by mutualizing an existing stock company. Many of the huge mutuals with which you are familiar were formed in this manner.

Today's mutuals are technically classified as mutual legal reserve companies, which means that they meet the same state capital requirements that are placed on stock companies. Most states do require mutuals to incorporate, and the policyowners control the corporation by voting for the board of directors which operates the company.

While the biggest legal difference between a mutual and a stock is that a mutual has no stockholders, the most visible difference is that the mutual company pays policy dividends to policyowners and the stock does not. It is important to note that these policy dividends are not a return on investment in the sense of the dividends paid by stock companies to stockholders. In the truest sense, policy dividends are a return of premium overcharge. In setting premium rates, a company makes many assumptions regarding mortality (death), anticipated earnings and expenses. Although a policy dividend is never guaranteed, generally company projections are quite conservative, the company does better than anticipated, and a dividend is paid. While some money must be held as surplus in the event of adverse experience in the future, the excess surplus is returned to the policyowner as a dividend - a return of unneeded premium. Because the policyowners participate in the profits of a mutual company, the mutual company is often called a participating company. A mutual company, then, may be distinguished from a stock company by the following:

- It is operated for the ultimate benefit of the policyowners. It has no stockholders.
- It generally pays policy dividends. Since the policyowners do participate in the profits of the company, it is called a **participating company**.
- There is no capital stock, so no stockholder dividends are paid.
- As there are no stockholders, the policyowners elect the board of directors of the company.

Note: One of the most common state test questions asks the difference between a stock company and a mutual company. The answer you want to look for is "ownership."

Reciprocals

From the viewpoint of the policyowner, a reciprocal insurance exchange operates like a mutual company. The biggest difference is structural. A reciprocal is an unincorporated entity managed by an attorney-in-fact generally offering homeowners or auto insurance to the public. Each insured member is known as a subscriber and agrees to share in the other subscriber's insured losses as they agree to share in his. It is from this reciprocal promise that the name is derived. In most jurisdictions, these not-for-profit organizations are regulated just like mutuals and must belong to the Insurance Guaranty Associations of the states in which they do business.

Fraternal

In the late 1800's and early 1900's, waves of European immigrants began to land on the shores of this country. While they came for many reasons, they were welcomed as necessary labor in the factories of America which were operating at full capacity throughout the period known as the Industrial Revolution. These new city dwellers naturally grouped together in accordance with their ethnic and religious backgrounds and often formed fraternal societies to maintain their national heritage. Such religious and social fraternities began to provide small amounts of insurance, generally burial insurance, for their members.

They grew rapidly until the turn of the century. They have since declined in importance, although some very large fraternal still exist today, including the Aid Association for Lutherans, Independent Order of Foresters, Lutheran Brotherhood, Woodsmen of the World, Knights of Columbus and Modern Woodsmen of America.

Fraternal are not normally incorporated under state insurance laws as are insurance companies, and are usually subject to slightly different regulations than stock or mutual companies. They do, however, closely parallel mutual companies in their organization and operation. The biggest difference is that you must join the fraternity in order to buy fraternal insurance.

Note: Any state exam question that references either a “lodge system” or “society” if referring to fraternal.

Government Insurers

In terms of dollar volume and number of policyowners, the federal government is by far the biggest insurance company on the face of the earth. Social Security and Medicare alone involve just about every U.S. citizen. In addition, programs are available for military personnel (Serviceman’s Group Life) and their families (CHAMPUS).

The federal government also provides or subsidizes insurance for some catastrophic perils like flood. State government is involved in providing insurance for those who cannot buy through normal channels in the areas of medical expense, homeowners and automobile insurance. State government also plays an important role in Worker’s Compensation insurance in most states.

Classification of Insurers

By Origin

In order for an insurance company to be granted a charter in a particular state it must have sufficient resources on hand to pay claims. The company anticipates that eventually enough policies will be sold to allow the Law of Large Numbers to work properly

A company chartered in Texas, for example, would be considered a Texas **domestic company**. If a company is chartered in another state, territorial possession or Washington D.C., it would be considered a **foreign company**. Therefore, a company chartered in Illinois would be a foreign company within the state of Texas. A company chartered in another country would be viewed as an **alien company**.

Almost always, a company’s home office is in the state in which it was formed - it is said to be domiciled there. Therefore, if we assume that we all live and work in Ohio, a company domiciled in New York would be considered foreign. A company domiciled in Canada would be considered an alien company.

By Authority

A newly formed company will usually be granted the right to do business in its state of origin. If that company wants to do business in other states, it must apply to those states for approval as an **authorized (or admitted) company**. For example, a company domiciled in Indiana and authorized to do business in Kentucky, Ohio and Illinois is an authorized (or admitted) company in those states only. In any other state the same company would be an **unauthorized (or nonadmitted) company**

Requiring a company to be authorized before doing business in a given state gives that state’s residents the assurance that their own state officials have approved the financial soundness, the method of operation and the policies sold by almost any company soliciting their business in that state.

The almost applies to a situation which rarely occurs in insurance - particularly on the life and health side of the business. It is possible to buy insurance from an unauthorized insurer in what is known as a **surplus lines transaction**.

Here's how it works. Suppose you are an Ohio resident and need an insurance policy unavailable from any Ohio authorized company

If the coverage you need is available, say, from a Texas company unauthorized in Ohio, you do not have to fly to Dallas to purchase it. You could buy what you need through an Ohio-licensed Surplus Lines agent. Typically, states grant this additional license only to individuals who are already resident agents in good standing and place some additional administrative requirements upon them.

You must understand that the "authority" or "authorization" to transact business in a state is given by the Commissioner (Director or Superintendent) of Insurance of that state by granting an insurance company a "certificate of authority." The **certificate of authority** is the insurance company's license to do business in that state. Therefore, the insurance company receiving a certificate of authority (license) is said to be authorized or admitted into that state to transact business.

Last, the certificate of authority will specify what types of insurance an insurer can market; i.e., life insurance only, health insurance only or life and health insurance. Additionally, the certificate of authority is not perpetual. Like most agent/producer licenses, it must be renewed.

By Financial Soundness

One important task you have as an agent/producer is to make sure you are insuring your clients with policies from companies that are financially sound. This **due diligence** effort is particularly important if you are an independent agent representing, say, 20 companies.

There are several **independent rating services** that assess the financial strength of insurance companies based upon that company's claims experience, investment earnings, level of reserves, management and other factors. Amongst these organizations are the A.M. Best Company, Moody's Investors Service, Standard and Poor's Insurance Rating services and others. One of the easiest ways to determine the financial soundness (or unsoundness) of an insurance company is to check them against the ratings they are given by one of these services.

For example, a superior company on the A.M. Best scale gets an A+. A grade of C or C- is considered marginal. A rating of D, E or F is below (or way below) minimum standards.

Life and Health Guaranty Association

Authorized/admitted insurers must become members of the state guaranty association as a requirement to be issued a certificate of authority in that state. You can conclude from this statement the following important points:

1. Nonadmitted insurers are not members of the Life and Health Guaranty Association.
2. Surplus lines insurers are not members of the Life and Health Guaranty Association.

The question is, what is the Life and Health Guaranty Association? It is an association of admitted insurers who have pledged money to protect policyholders insured by a member (admitted) insurer experiencing financial difficulty.

If a member insurance company becomes insolvent, the Guaranty Association will assess its member companies to pay the claims of insured persons living in this state and, in other cases, to keep coverage in force that was provided by the insolvent company. The Guaranty Association is a non-profit legal entity under the supervision of the insurance department. All insurance companies shall be and remain members of the Guaranty Association as a condition of their authority to transact business in a given state.

Guaranty Association Coverage Limits - Obviously, the Guaranty Association cannot pay more than what the insurance company would owe under a policy. The Association will pay a maximum of \$300,000 on any one (1) insured life, regardless of how many policies the insured had with the insolvent insurer. Further, the Association will not pay more than:

- \$100,000 in cash surrender values
- \$100,000 in present value annuities
- \$100,000 in health benefits
- \$300,000 in life death benefits

Note: These dollar amounts will be on the state exam and are generally national standards.