FYI EXPRESS

STUDY MANUAL

Dear Student:

Thank you for purchasing the Georgia 40-hour Property and Casualty insurance Agent Exam Study Manual. The State Exam will be one of the most challenging tests you will take as you prepare to enter or advance in the insurance industry. This study manual will help you understand the concepts and terms you need to pass the state exam by pinpointing areas of the Content Outline you will need to focus on. Memorizing is good but many students make the mistake of memorizing terms and then think they are ready for the state exam. Unfortunately, students figure out the hard way that just memorizing terms does not equal success.

By focusing on specific areas, writing out answers to questions, and practicing taking similar state exams, you will be best prepared for the state exam. Remember, it's not just terms you need to know but also concepts. For example, instead of just knowing what an Uninsured Motorist is, you need to know how it works within the PAP policy, what the difference is between stacked and non-stacked, and in what ways does each benefit the insured. If you have no idea what I was referring to, then I'm glad you purchased this study manual.

The study manual is broken into ten chapters with Practice Exams to test your understanding of each.

Before you begin studying let me give you some tips to being successful:

- Even though some sections weigh heavier on the state exam, know all the information in the study manual.
- After you have successfully answered the Practice Exam questions, have someone ask you the questions and then see if you can discuss the answers. Along with writing the answers this makes retaining the information easier.
- Set goals to learn at least one concept a day.
- At the beginning of each study session, review and recall previously learned material.
- Repetition stimulates long term memory.

When you feel ready to take the State Exam, you should take the Final Exam I created to test your knowledge of all the topics in this study manual.

If you correctly answer at least 70% of the multiple choice questions, you will earn a Certificate to use when you apply for the State Exam.

Here's the link to the Final Exam:

If you put forth the effort in knowing this material, you will successfully pass the state exam.

Good Luck!

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This ebook covers everything insurance agents need to know about learning Property & Casualty Insurance, including different types of coverage, common risks, and best practices for helping clients choose the right policy. It would be a valuable resource for agents looking to expand their knowledge and better serve their clients in the insurance market.

As you go through the eBook and have enjoyed a few topics, I give you the opportunity to test your understanding of what you just read by clicking a link.

The link will take you to a quiz with multiple-choice questions & 4 possible answers.

It is not mandatory to take the quizzes but it sure is fun (especially if you turn on the music, memes & sound effects.

Besides, these are the type of questions you will have on your State Exam.

To get the most out of this eBook, you need to sign up for a FREE account at https://quizizz.com/

I. PROPERTY: TYPES OF POLICIES

A. Homeowners

1. HO-2 (Broad Form)

Definition: Provides coverage for a broader range of perils than HO-1, including damage from fire, lightning, windstorm, hail, explosion, and more.

Example: If a tree falls on your house during a storm, an HO-2 policy would cover the damage.

2. HO-3 (Special Form)

Definition: The most common type of homeowners insurance, offering coverage for all perils except those specifically excluded.

Example: Covers damage from a fire but may exclude damage from floods.

3. HO-4 (Contents Broad Form)

Definition: Also known as renters' insurance, it covers personal property and liability for tenants.

Example: If your rented apartment is burglarized, HO-4 would cover the stolen items.

4. HO-5 (Comprehensive Form)

Definition: Offers the most extensive coverage, including for personal property on an open-perils basis.

Example: Covers accidental damage to your belongings, like spilling paint on your carpet.

5. HO-6 (Unit Owners Form)

Definition: Designed for condo owners, covering personal property and the interior structure of the unit.

Example: If a pipe bursts in your condo, HO-6 would cover the repairs.

6. HO-7: Mobile Home Form

Definition: The HO-7 insurance policy, also known as the Mobile Home Form, is a type of homeowners insurance specifically designed for mobile homes, manufactured homes, and other factory-built homes. It provides coverage similar to an HO-3 policy but is tailored to the unique needs and risks associated with mobile homes2.

Example: Jane owns a double-wide manufactured home. She purchases an HO-7 policy to protect her home against perils like fire, theft, and windstorms. The policy covers the structure of her home, her personal property inside the home, and provides liability coverage in case someone is injured on her property.

7. HO-8 (Modified Coverage Form)

Definition: Provides coverage for older homes where the replacement cost exceeds the market value.

Example: Covers repairs to a historic home with unique architectural features.

Types of homeowners insurance

HO-2: A more common policy type for single-family homes and a slight upgrade from the HO-1.

HO-3: The **most common** type of homeowners insurance policy for single- family homes, with broader coverage than the HO-2.

HO-4: A policy type that is specifically for tenants and is referred to as renters' insurance.

HO-5: The most comprehensive form of homeowners insurance and the second most common policy type for single-family homes.

HO-6: A type of coverage designed for condo owners.

HO-8: A special type of homeowners insurance for older properties that cost more to rebuild than what they're actually worth on the market.

HO-2: Broad Form

An HO-2 policy offers more coverage than an HO-1 policy, but still not as much as a standard HO-3 policy.

With a broad form policy, the following are protected:

- Physical structure of your home at its replacement cost value
- Unattached structures at their replacement cost value
- Personal property at its actual cash value
- Additional living expenses
- Liability
- Medical payments to others

HO-2 policies also offer protection from six additional named perils:

- Weight of ice, snow, or sleet
- Accidental discharge or overflow of water or steam
- Sudden and accidental tearing apart, cracking, burning, or bulging of a built-in appliance like a water heater, or centralized air conditioner or heating system
- Freezing
- Sudden and accidental damage from an artificially generated electrical current, like power surges
- Volcanic eruption

HO-2 policies also aren't very common and only made up 6.7% of single- family home insurance policies countrywide in 2021, according to the NAIC.

What is HO-3 insurance?

An HO-3 policy is the most common type of homeowners insurance policy in the U.S., accounting for roughly 78% of all home policies as of 2020. [1] Also called special form homeowners' insurance, HO-3 insurance allows insurers to write comprehensive home insurance coverage at relatively affordable rates for homeowners.

While most home insurance is based on the HO-3, the specifics of your policy could vary depending on your location and insurance provider. For example, some policies may have fewer exclusions or better claim settlement terms than others. This is why it's important to read through your policy and compare home insurance policy options from several companies to ensure you're getting the right coverage for your needs.

Key takeaways

HO-3 insurance is the most popular kind of homeowners insurance, providing coverage against all perils except for the ones specifically listed in your policy.

An HO-3 policy is a package policy, which means it includes several types of coverage — most notably dwelling, personal property, and liability.

While you still may be able to purchase HO-2 insurance, it provides significantly less protection than the HO-3 or more comprehensive HO-5 policy option.

What does an HO-3 policy cover?

An HO-3 homeowners insurance policy covers your home, personal belongings, and finances in the event your property is damaged or you're held liable for an accident. Here are the six main coverages in every standard HO-3 policy.

HO-3 coverages

Coverage	What it covers	Typical amount
Dwelling	Your house and attached structures, such as a deck	Home's rebuild cost
Other structures	Standalone structures on your property, such as a barn or shed	10% of dwelling limit
Personal property	Your possessions, such as furniture, kitchen appliances, and electronics	50% of dwelling limit
Loss of use	Temporary living expenses while your home is being repaired	30% of dwelling limit
Personal liability	Legal and medical bills if you're held liable for an injury	$100,000 to $500,000
Medical payments	Minor injuries to houseguests	$1,000 to $5,000

Dwelling coverage

The dwelling coverage section of your policy covers damage to the home's structure, and anything attached to it, such as a garage or porch. If your house is damaged by a covered loss, your insurance can help pay for repairs or rebuilding costs up to the dwelling limit in your policy.

HO-3 policy exclusions

In an HO-3 policy, your home (dwelling) and standalone structures on your property (other structures) are protected on an **open perils** basis, which means all types of damage or loss are covered **except** for the exclusions listed on the policy. That means when you file a dwelling or other structures claim, the **burden of proof falls on the insurer** to prove the damage or loss is not covered by your policy.

Here are the most common HO-3 insurance exclusions:

- Earthquakes
- Flooding
- Government action
- Intentional loss
- Neglect
- Nuclear hazard
- Ordinance or law
- Power surges that originate off your property
- War

Personal property coverage

The personal property section of your policy helps cover the cost of your damaged or stolen personal belongings, such as furniture, clothes, jewelry, and electronics. This coverage applies to belongings inside your house and anywhere else in the world — up to the limits in your policy.

HO-3 named perils

In an HO-3 policy, your belongings are protected on a **named perils** basis.

This means your insurance will only cover damage or loss caused by the 16 specific perils listed in your policy. With this coverage, the **burden of proof is on you** (not your insurer) to prove the loss was caused by one or more of the named perils.

- Fire or lightning
- Windstorm and hail
- Explosion
- Riot or civil commotion
- Damage caused by aircraft
- Damage caused by vehicles
- Smoke
- Volcanic eruption
- Vandalism and malicious mischief
- Theft

- Falling objects
- Weight of snow, ice, or sleet
- Accidental discharge/overflow of water
- Sudden tearing/cracking of appliances
- Freezing
- Power surges

Additional living expenses

If your house is badly damaged, your policy's loss of use coverage can help cover the cost of temporary lodging and relocation expenses while it's being repaired or rebuilt. Expenses that are typically covered include hotels bills, restaurant meals, pet boarding fees, and more.

Liability coverage

Liability coverage protects you and your finances from expensive lawsuits if you're ever held liable for someone else's injury or damaged property. This section of your policy also comes with medical payments coverage that pays out for minor injuries to houseguests — regardless of fault.

HO-3 insurance vs. other types of homeowners insurance

HO-3	Most single- family homes	Dwelling, personal property, liability	Named (personal property) and Open (dwelling)
HO-4	Rental units	Personal property, liability	Named
HO-5	High-value homes	Dwelling, personal property, liability	Open
HO-6	Condo or co- op units	Dwelling, personal property, liability	Named

HO-8	Older homes	Dwelling, personal property, liability	Named

There are several types of homeowners insurance policies for various property types and coverage needs. An HO-4 policy, for example, is specifically to protect renters. And an HO-6 policy is designed primarily for condo owners.

HO-3 vs. HO-2 and HO-5

The most common type of homeowners insurance is the HO-3, but some insurers still write coverage on the HO-2 form — particularly for higher risk properties — and the HO-5 is the preferred policy option for high net-worth homeowners with more expensive possessions and multiple property types to insure.

HO-2 policy: Also known as broad form insurance, HO-2

insurance is the cheapest and most limited home insurance policy option. It covers your home, additional structures, and belongings from the 16 named perils listed above.

HO-3 policy: With HO-3 insurance, your home and additional structures on your property are protected with the more comprehensive open perils coverage, while your belongings are protected with named perils coverage.

HO-5 policy: Also called comprehensive form insurance, HO-5 insurance is the most expensive and robust type of homeowners insurance you can buy. It covers your home, additional structures, and personal belongings with open perils coverage.

HO-3: Special Form

An HO-3 policy is the **most common** type of homeowners insurance on the market, accounting for 78.2% of home insurance policies in 2021, according to the NAIC.

HO-3 policies include coverage for the physical structure of your

home, other structures on your property, personal belongings, additional living expenses, personal liability, and medical payments to others.

By default, HO-3 policies cover your home at its replacement cost and your personal property at its actual cash value. However, most insurance companies will let you add a replacement cost personal property endorsement to your policy for a small fee.

17 common homeowners' insurance policy endorsements

Here are some of the most popular home insurance policy endorsements:

Guaranteed replacement cost coverage

Your homeowner's insurance dwelling coverage is based on your home's replacement cost value, which is how much it'd cost to rebuild your home from the ground up with similar build materials. You can extend these coverage limits with a guaranteed replacement cost endorsement.

How it works

By upgrading your policy with guaranteed replacement cost, your insurer will pay the full cost for your home to be rebuilt and restored to its condition before the damage — regardless of your policy limits.

How much it costs

Guaranteed replacement cost coverage is one of the more expensive home insurance policy add-ons, and usually costs around 5% to 10% of your total policy premium. That means if your policy has an annual premium of $2,000, adding guaranteed replacement cost coverage would likely cost an extra $100 to $200 a year.

Extended replacement cost coverage

Extended replacement cost coverage is a home insurance add-on that extends your dwelling coverage limit an additional 10% to 50%. Home rebuild costs often increase after natural disasters and during periods of inflation, making this a valuable coverage in 2024.

How it works

By upgrading your policy with extended replacement cost, your insurer will pay for your home to be rebuilt and restored to its condition before the damage, even if the damage amount is higher than your dwelling coverage limit. Depending on how much coverage you get, you could be insured for anywhere from 110% to 150% of your home's rebuild cost.

How much it costs

Most major home insurance companies offer extended replacement cost coverage for an additional $25 to $50 a year.

Personal property replacement cost coverage

Personal property replacement cost coverage pays to replace your belongings with new items of similar type and quality — without deducting for depreciation.

How it works

By upgrading your personal property coverage at its replacement cost, your insurance company will pay to replace your furniture, clothing, electronics, and other belongings with new items — regardless of how old or worn they are.

How much it costs

The cost to update your personal property coverage to its replacement cost varies by company and policyholder.

Inflation guard coverage

Inflation guard coverage is a home insurance coverage endorsement that automatically increases your policy's dwelling coverage limit — typically between 4% and 8% — to reflect the current construction and labor costs in your area.

How it works

Coverage is calculated per day, and increases your dwelling coverage — as well as your insurance premium — at your annual policy renewal. If your home is damaged in the middle of your policy term, your inflation guard coverage is calculated on a prorated basis.

Let's take a look at an example.

Say your home is insured for $100,000 and your inflation guard coverage is set at 8%. Now say you suffer a total loss of your home 90 days into your year-long policy term. Your dwelling coverage limit will be increased to reflect an 8% daily inflation rate, so your coverage limit would now be around $101,973, instead of $100,000.

How much it costs

The cost to add inflation guard coverage to your home insurance policy varies by company and coverage limits.

Ordinance or law coverage

Ordinance or law coverage is a home insurance add-on that covers the extra cost of getting your home up to code after a covered loss, including home construction, demolition, remodeling, and renovations.

How it works

Most city, state, or county governments have building codes around how homes must be built to ensure everybody's safety. Because building codes change frequently as construction techniques improve, it's likely your home isn't up to current building codes.

That's where ordinance or law coverage comes in. If your home is damaged in a covered incident, this endorsement will cover the extra costs to bring your home up to code while making other repairs.

What it costs

Most home insurance companies offer a limited amount of ordinance or law coverage that comes standard with your home insurance policy. But you can often purchase higher coverage limits for an additional fee. How much it costs will vary depending on where you live, your insurer, and how much additional coverage you purchase.

Flood insurance endorsement

A flood insurance endorsement covers your home and personal belongings against water damage caused by flooding, including high tides, hurricane storm surge, heavy rain, and other sources of natural flooding. A typical homeowners insurance policy does not cover flood damage, so if you live in a flood zone or close to a body of water, consider filling in this important coverage gap with a flood insurance endorsement.

How it works

Kin, Tower Hill, Narragansett Bay, and a few other home insurance companies offer a rare private flood insurance endorsement you can add on to your standard home insurance policy for an additional premium. This covers the cost of repairs and other expenses if your home is damaged in a flood.

What it costs

The average cost of private flood insurance is around $1,074 per year, according to our 2023 analysis of flood insurance pricing data from the National Association of Insurance Commissioners. However, you might be able to receive a discount if you purchase flood insurance as an endorsement to your standard home insurance policy.

Water backup coverage

If water backs up through a sewer or overflows through a sump pump and damages your home's foundation or your personal belongings, home insurance won't reimburse you for repairs or new items. Water backup coverage supplements that gap in coverage.

How it works

Water backup coverage protects your home and personal property from water damage caused by backed up drains, sewage systems, and sump pumps, even if the discharge occurred due to mechanical issues.

How much it costs

You can usually add between $5,000 to $25,000 in water backup protection to your policy for about an additional $30 to $70 a year. To decide on a coverage amount that works for you, consider how much it would cost to replace your flooring, furniture, and personal belongings if they were damaged by a sewer or drain backup.

Water backup coverage doesn't cover damage to the sump pump or plumbing

Water backup coverage only covers water damage caused by sewer, drain, or sump pump backups. But it won't pay to replace or repair the actual pumps or drains.

Equipment breakdown coverage

Home insurance covers your appliances if they're damaged by a covered peril, like a fire. But it won't pay to repair or replace them if they break due to mechanical or electrical failure — but equipment breakdown coverage does.

How it works

With equipment breakdown coverage, a variety of appliances and devices in your home are covered in the event that they break down due to mechanical or electrical failure, including:

- Boilers and furnaces
- Computers and related equipment
- Heating and air conditioning systems
- Home entertainment systems
- Home security systems
- Washers and dryers
- Refrigerators and freezers
- Ovens and microwaves
- Water heaters

Equipment breakdown coverage may also cover food spoilage if your freezer or refrigerator stops working and you're out all of that food.

How much it costs

Equipment breakdown coverage can cost about $25 to $50 annually for around $50,000 in coverage per occurrence. In most cases, you need to pay a deductible of $250 to $500 before your coverage kicks in.

Equipment breakdown coverage doesn't cover maintenance issues

If your appliances break down due to wear and tear, defects, rust corrosion, pest damage, or anything else that can be considered a maintenance problem, you won't be reimbursed for repairs.

Service line coverage

Standard homeowners' insurance will generally repair damage to your home caused by ruptured utility lines beneath your property, but it won't cover repairs to the service lines themselves. You can add service line coverage to your policy to enhance coverage for your service lines.

How it works

With service line coverage, you can get reimbursed for backed up or punctured utility lines, including:

- Cable lines
- Drain pipes
- Fiber optics
- Internet lines
- Natural gas pipes
- Power lines
- Sewer pipes
- Sprinkler pipes
- Steam pipes
- Water pipes

You're also insured against damage to your services lines that isn't covered in a standard policy, including:

- Mechanical or electrical breakdown
- Mold, fungus, or wet rot
- Regular wear and tear
- Tree or root-caused damage
- Smog, rust, or other corrosion
- Vermin, insects, or rodent damage

How much it costs

Service line coverage generally costs about $30 annually for $10,000 in coverage, but depending on your insurance provider you may have the option of setting higher coverage limits.

Scheduled personal property coverage

Certain types of personal property, like jewelry, silverware, and electronics may be subject to sublimits, meaning you won't be insured past a certain coverage amount — usually a $1,000 to $2,500 blanket limit for each category. To extend that coverage limit, you can purchase a scheduled personal property endorsement.

How it works

A scheduled personal property endorsement can raise your payout limits for expensive property. Scheduled personal property coverage also stretches your policy protection to cover misplaced items.

Property types insured by scheduled personal property coverage include:

- Electronics
- Expensive antiques
- Fine art
- Firearms
- Furs
- Jewelry
- Musical instruments
- Silver and goldware
- Tech devices (cameras, computer systems, etc.)

How much it costs

Covered property types and coverage limits vary from company to company. Costs will also depend on if you're insuring multiple items — like a collection of watches — versus just one item. Generally, you can expect to pay around $100 for each $10,000 in scheduled coverage for a class of items.

Identity theft coverage

Some insurers automatically include identity theft coverage in standard policies, but if they don't you may be able to add identity theft coverage as an endorsement. It covers the costs associated with identity theft recovery.

How it works

Identity theft coverage helps pay for costs associated with recovering your identity, but it doesn't include monetary reimbursement, like if someone drains your bank account. Policies vary by insurer and state, but you're usually covered for fraud services, ID replacement, identity restoration, loss of income, and attorney and administrative fees. You can choose to enhance your identity protection with cyber-attack coverage, cyber extortion coverage, or fraud coverage.

How much it costs

It'll depend on the insurance company, but you may be able to add $15,000 in identity theft coverage to your policy for an additional $25 to $60 a year.

Home business coverage

The maximum payout for home business property is typically $2,500 in a standard homeowners insurance policy. If you have laptops, cameras, and other tech devices you use for work, $2,500 may not be enough coverage to fully replace everything you lost if your home office was damaged or broken into.

How it works

Home business coverage can extend financial protection to your business property and raise your coverage limits. This endorsement does not include liability coverage.

How much it costs

The cost will depend on the size of your business and your insurance company. Generally, a home business endorsement costs an additional $25 annually to increase your coverage limits to $5,000. If you have a larger home business, you may need an in-home business policy, which is a separate policy that you can buy — they typically offer up to $10,000 in coverage.

Dwelling under construction coverage

If your house is under construction or vacant for more than 60 days, standard homeowners' insurance typically won't cover your home due to the increased risk of theft, vandalism, and storm-related damage. Your coverage generally won't pick back up until the renovations are finished and the home is occupied.

How it works

A dwelling under construction endorsement covers theft and damage to building materials while your home is under construction. You can also consider other supplemental coverage options like vacant homeowners' insurance and builder's risk insurance if you're planning on living elsewhere while your home is being worked on.

How much it costs

Costs will depend greatly on the scope of the project. You can expect to pay more in premiums once the project is done, since any additions or upgrades you made will increase your home's rebuild value.

Sinkhole coverage

Home insurance does not cover sinkholes or any other form of earth movement, like a mudslide. But your insurer may offer a sinkhole coverage endorsement.

How it works

In certain states where sinkholes are more common — like Florida and Tennessee — insurers may be required by law to offer sinkhole coverage. Sinkhole coverage helps pay to repair your home, its foundation, and it covers the cost of stabilizing the ground if your home begins to collapse into a sinkhole.

How much it costs

Sinkhole damage can be catastrophic, and coverage costs vary by state and insurance company. If you need more protection, you may be able to purchase a standalone sinkhole insurance policy.

“Catastrophic ground collapse coverage” is automatically included in Florida home insurance policies

Because sinkholes are so common in Florida, catastrophic ground collapse coverage is included in standard home insurance policies. In order for this coverage to be used, the following damages would need to occur:

- The abrupt collapse of ground cover
- A depression in the ground cover that is visible to the naked eye
- Structural damage to your home, including the foundation
- The insured structure being condemned and ordered to be vacated by the governmental agency authorized by law to issue such an order for that structure

Windstorm coverage

Wind and hail damage are covered perils in a standard homeowners insurance policy, but if you live in an area that is at high risk for hurricanes or other kinds of windstorms, wind and hail damage may be excluded from your policy.

How it works

If you live in an area that is prone to frequent severe storms — like the East Coast — wind damage may be excluded from your insurance. If that’s the case, your insurer may offer wind coverage as an endorsement. If they don’t, you can purchase separate windstorm insurance.

How much it costs

Like sinkhole coverage, costs vary according to coverage amounts. It'll also depend on your home's build materials, age, and location

Earthquake coverage

Earthquake damage is an excluded peril in a homeowners insurance policy.

How it works

Some insurance companies offer earthquake endorsements. The endorsement essentially adds earthquake coverage from your policy — so it covers the costs of rebuilding your home, replacing your belongings, and paying for additional living expenses in the event an earthquake destroys your residence. You can also purchase standalone earthquake insurance.

What it costs

The cost of an earthquake insurance will depend on your home’s location and the extent of coverage you need. Earthquake endorsements are significantly cheaper than a separate earthquake insurance policy.

Flood damage is also excluded from homeowners insurance coverage

Most flood insurance policies are sold through FEMA's National Flood Insurance Program (NFIP). If you have an NFIP flood insurance policy and want to change your coverage amounts in the middle of the policy term, you'll need to add an endorsement to your policy in order to do so.

Loss assessment coverage

Loss assessment coverage is a home insurance add-on that covers your portion of damage to common areas you're responsible for if you live in a shared community — like a condominium building or a neighborhood with a homeowner's association (HOA).

How it works

Most damage to shared spaces like your community clubhouse or pool area is covered by your HOA's master policy, which is paid for by membership dues. If this shared space gets damaged or a guest has an accident, your community's HOA insurance will cover the loss up to its coverage limits. The remaining bill is split equally among the homeowners in the community.

That's where loss assessment coverage comes in. It's designed to cover these leftover costs, so you don't have to pay for your share out of your own pocket.

What it costs

A loss assessment coverage endorsement usually costs anywhere from

$25 to $50 a year on top of your standard home insurance policy premiums.

When it comes to perils, HO-3 policies provide all-risks coverage for your home. Also known as open-perils coverage, all-risks coverage means your policy covers everything **except** the causes of loss that are specifically listed in your policy — called home insurance exclusions.

Covered perils

HO-3 policies protect your home and belongings from these 16 perils:

- Fire or lightning
- Windstorm or hail
- Explosion
- Riot or civil commotion
- Aircraft
- Vehicles
- Smoke
- Vandalism
- Theft
- Falling objects
- Weight of ice, snow, or sleet
- Accidental discharge or overflow of water or steam
- Sudden and accidental tearing apart, cracking, burning, or bulging of a built-in appliance like a water heater, or centralized air conditioner or heating system
- Freezing
- Sudden and accidental damage from an artificially generated electrical current, like power surges
- Volcanic eruption

Excluded perils

HO-3 policies **don't** cover:

- Ordinance of law
- Earth movement
- Water damage from flooding, sewer backups, or water that seeps up from the ground
- Power failure
- Neglect
- War
- Nuclear hazard
- Intentional loss
- Government action
- Theft to a dwelling under construction
- Vandalism or malicious mischief (if the home was vacant for more than 60 days)
- Mold, fungus, or wet rot (except if it resulted from an accidental discharge or overflow of water)

- Wear and tear
- Mechanical breakdown
- Smog, rust or other corrosion
- Smoke from agricultural smudging and industrial operations
- Discharge, dispersal, seepage of pollutants
- Settling, shrinking, bulging, or expanding of parts of the structure like your foundation or walls
- Birds, vermin, rodents, insects Animals owned by insured

Key takeaways

HO-3 insurance is the most popular kind of homeowners insurance, providing coverage against all perils except for the ones specifically listed in your policy.

An HO-3 policy is a package policy, which means it includes several types of coverage — most notably dwelling, personal property, and liability.

While you still may be able to purchase HO-2 insurance, it provides significantly less protection than the HO-3 or more comprehensive HO-5 policy option.

HO-4: Contents Broad Form

Better known as renters' insurance, HO-4 policies cover your personal belongings both inside your rental property and anywhere else in the world. In other words, if your laptop is stolen from your hotel room while on vacation, renters insurance may help reimburse you for a new one.

Renters insurance covers renters' property from damage or loss caused by the **same 16 named perils** found in HO-2 and HO-3 policies. Personal belongings are usually covered at their replacement cost but check with your insurance provider to be sure.

Renters insurance also comes with liability coverage and additional living expenses coverage if your apartment is damaged, and you need to temporarily live somewhere else.

However, HO-4 policies do **not** include dwelling coverage for the physical structure of the home since these policies are designed for renters and not homeowners. If the apartment or house you're living in is damaged, it’s your landlord’s responsibility to fix it or file a claim using their own insurance coverage.

HO-5: Comprehensive Form

HO-5 homeowners insurance provides the highest level of coverage for single-family homes.

It's designed for high-value properties that require higher dwelling coverage limits, extra protection for possessions and expensive keepsakes, and access to coverage add-ons not found on standard policies.

While HO-5 home insurance is very similar to HO-3 policies, there are some notable differences.

HO-5 policy

Dwelling **and** personal property are insured at their replacement cost by default.

All-risks coverage for both your home and personal belongings.

High coverage limits for expensive types of property with normally strict coverage limits, including jewelry, fine furs, and certain electronics.

HO-3 policy

Dwelling is insured at its replacement cost and personal property is insured at its actual cash value.

All-risks dwelling coverage but named perils personal property coverage.

Limited coverage for expensive types of property, like jewelry, fine furs, and certain electronics.

Because of the robust coverage you get with an HO-5 policy, rates are typically more expensive than any other policy type on this list. HO-5 policies only accounted for 13% of home insurance policies in 2021, according to the NAIC.

HO-6: Unit-owners Form

Also known as condo insurance, an HO-6 policy is for people who live in a condominium or co-op unit. It protects the interior of your condo (aka dwelling coverage) and the personal belongings inside from the 16 perils listed in your insurance policy (the same found in HO-2 and HO-3 policies).

The amount of dwelling coverage you need in your condo policy varies based on what's already covered under your condo association's master policy. A master policy typically covers the exterior structure of the condo building and any common areas.

Most condo owners will at least want enough dwelling coverage to cover the cost of upgrades or renovations to the unit, such as a remodeled kitchen or bathroom with custom tiles and fixtures.

Condo insurance also comes with additional living expenses, personal liability, medical payments to others, and loss assessment coverage.

HO-7: Mobile Home Form

HO-7 insurance, more commonly known as, is basically an HO-3 policy that's designed specifically for mobile, manufactured, and other factory-built homes.

Here are the different types of mobile homes covered under an HO-7 policy:

- Trailers, travel trailers, fifth-wheel trailers
- Single-wide manufactured and single-wide mobile homes
- Double-wide manufactured and double-wide mobile homes
- Sectional homes
- Modular homes
- Park model homes and RVs

HO-7 policies include coverage for the physical structure of your mobile home, other structures on your property, personal belongings, additional living expenses, personal liability, and medical payments to others. Like with HO-3 policies, both your mobile home and personal belongings are covered by the 16 perils listed in your policy.

HO-8: Modified Coverage Form

HO-8 homeowners' insurance is designed for older or historic homes with ornate features and other characteristics that would be difficult to replace. You generally need HO-8 insurance if your home's replacement cost is higher than its market value.

HO-8 insurance covers the physical structure of your home, other structures on your property, personal belongings, personal liability, additional living expenses, personal liability, and medical payments to others.

HO-8 insurance is covered on a **named perils** basis and only covers **10 perils.** If your home is damaged by a covered peril, HO-8 policies typically pay out the actual cash value of the structure of your home and personal belongings rather than its replacement cost.

Some carriers may also offer HO-8 policies that pay for damage to property that's hard to replace on a functional replacement cost basis. For example, a home with antique windows and hardwood flooring may be replaced with cheaper and more modern replacements.

HO-8 policies only accounted for 0.4% of home insurance policies in 2021, according to the NAIC.

What factors affect the price of older homes?

Homeowners insurance is based on the replacement cost value of your home, meaning the amount it costs to rebuild your home from the ground up. The price of homeowners insurance depends on a variety of factors, some which affect older homes more than newer ones.

Rare or expensive construction materials. Older homes tend to contain obsolete building materials and ornate features that are specific to the time period in which it was built. Plaster walls, stuccoing, and custom architectural details are all common characteristics and stylings of pre-war homes and are more expensive and less flexible than modern structural materials like sheetrock, plywood, and drywall.

Cost of labor. The masonry work and labor-intensive makeup of older builds require a contractor who is skilled in period architecture, and those contractors may charge a lot more for their services than a modern-home contractor.

Age of roof. If your roof is more than 15 or 20 years old, that could also impact your rates — your insurance company may even exclude the roof from coverage.

Why are older homes more expensive to insure than newer homes?

Generally speaking, the replacement cost of an older home is going to be higher than a home with a modern build. Since your insurance premiums are largely based on the home's replacement value as opposed to its market value, the basic architectural styling of your older home could be the reason for its high insurance premiums.

Certain details of the home — like the age of its roof or ornate features — also impact your homeowners insurance rates. Homes with aluminum wiring, for example, are more likely to have accidental fires, and older polybutylene or galvanized piping is more likely to corrode and deteriorate faster than modern pipes like PVC.

Can a home be too old to insure?

It can be difficult to find adequate, affordable coverage for an older home, especially if it's over 100 years old. If you're unable to find home insurance, consider reaching out to the National Trust Insurance Services (NTIS), a subsidiary of the National Trust for Historic Preservation. The NTIS works with multiple different insurance companies to help find coverage for older historic homes.

What happens if you can't get insurance on an older home?

If you can't find anyone to insure your older home, you may need to consider making updates to it — like replacing your old plumbing or wiring to make it safer and easier to replace. You may also need to make improvements to your roof.

What type of homeowners insurance should you get for older homes?

Depending on its age and architectural style, you may be able to cover your home with a standard homeowners insurance policy. But since many historic homes can cost millions of dollars to rebuild, you may need to get specialized high-value homeowners insurance to cover the home up to its full replacement cost.

Below are some insurance options for an older home:

- **HO-3 homeowners insurance policy**. This is the most common form of homeowners insurance, and you may qualify for an HO-3 policy if you have an old home. If you don't qualify for HO-3 insurance, you may only need to upgrade a few things about your home — like replacing your home's wiring or updating your roof — in order to get coverage.
- **National Trust Insurance Services (NTIS)**. Through its subsidiary the National Trust for Historic Preservation, the NTIS works with multiple insurance companies that specialize in insuring older, high-value properties with a replacement cost that far exceeds the home's market value.
- **HO-8 homeowners insurance policy.** An HO-8 policy is designed for homes where the cost to rebuild is greater than the market value — which is the case for many older or historic homes. HO-8 homeowners' insurance only reimburses you for damage on an actual cash value basis, which means the home's replacement cost minus its depreciation. That means if your home incurs a loss, this policy probably won't reimburse you for the more expensive historic building materials.

Additional coverage options for older homes

If you own an older home, you'll need a homeowners insurance policy with additional coverage to fully protect it. Consider adding the following types of protection to your homeowner's insurance policy:

Extended or guaranteed replacement cost coverage

With extended replacement cost coverage, your dwelling coverage is automatically increased an additional 25% to 50% in the event that your coverage limits are maxed out. Guaranteed replacement cost coverage is even better, reimbursing you for the full rebuild of your home regardless of how much it costs.

Water backup coverage

Water backup coverage covers your home and personal property against sewer or drain backups and is the perfect coverage add-on for a home with old piping.

Service line coverage

Service line coverage pays for damage to utility lines that run from your home to the street for which you, the homeowner, are personally responsible. If you live in an older home, there's a good chance that your utility lines are old as well, making a service line coverage endorsement an invaluable policy add-on.

Scheduled personal property coverage

Many historic, older homes are styled and furnished with antiques and artifacts that were indicative of the period the home was built. Your furnishings are covered under the personal property coverage component in your policy, but certain expensive valuables are protected by a limited amount of coverage — also known as a sublimit. To increase the coverage limits for an antique china set or rug, you'll need to add a scheduled personal property endorsement to your homeowner's insurance policy.

Roof replacement coverage

In the event of roof damage, some companies may only reimburse you for the roof's actual cash value if it's beyond a certain age, in some cases 10 to 15 years old. If that's the case with your home, check with your insurance company to see if the roof is covered for its replacement cost. If it's not, check to see if your insurer offers roof replacement cost coverage for an additional premium.

Ordinance or law coverage

Ordinance or law coverage is an endorsement that you can add to your homeowner's policy. This endorsement covers the cost of getting your house back up to code after a covered loss. For example, if your home burns down and the county requires it to be rebuilt with upgraded construction, ordinance or law coverage can help cover the increased costs. Keep in mind that means your older home may be rebuilt using more modern materials.

B. Dwelling Policies

DP-1 (Basic Form)

Definition: Covers basic perils like fire, lightning, and internal explosion.

Example: If a fire damages a rental property, DP-1 would cover the repairs.

DP-2 (Broad Form)

Definition: Provides broader coverage than DP-1, including additional perils like burglary and falling objects.

Example: Covers damage from a tree branch falling on a rental property.

DP-3 (Special Form)

Definition: Offers the most comprehensive coverage for rental properties, covering all perils except those specifically excluded.

Example: Covers accidental water damage from a burst pipe in a rental property.

Dwelling insurance will help pay to repair or rebuild your home if it's damaged by an event that's covered by your insurance, like a fire or hail.

Dwelling coverage protects the structure of your home — including your foundation, walls, roof and windows — along with any built-in appliances and attached structures, like a garage or porch.

What is dwelling coverage?

Dwelling coverage, also known as Coverage A, is the part of your homeowner's policy that covers repairing or rebuilding your home after it's damaged by something that's covered by your insurance, like a falling tree branch or bursting frozen pipes.

What is a dwelling?

Dwelling coverage is only one of the six coverage types included in a standard home insurance policy.

Homeowners insurance coverage types

Coverage A: Dwelling: Protects your home's structure.

Coverage B: Other structures: Covers detached structures, like a fence or pool.

Coverage C: Personal property: Protects your personal belongings, like furniture and clothing.

Coverage D: Loss of use: Helps pay extra living expenses if your home is damaged and you need to live somewhere else during repairs.

Coverage E: Personal liability: Protects you against a lawsuit if you accidentally hurt someone or damage their property.

Coverage F: Medical payments: Covers your guests' medical bills if they're hurt while visiting your home.

If you own a condo, parts of your home are shared with other owners in your building, like the roof and exterior walls. Condo insurance doesn't usually include coverage for other structures either. You'll need to check your condo association's master insurance policy to determine which parts of the building are your responsibility to protect and which parts fall under the master policy.

You should share this information with your insurance company to make sure your policy fully protects your condo.

What does dwelling insurance cover?

Most homeowners' insurance policies protect your dwelling against damage from the following:

- Burst pipes
- Car accidents
- Explosions
- Falling objects, including aircraft
- Fire, smoke and lightning
- Hail and wind
- Theft
- Vandalism
- Weight of snow or ice

Dwelling coverage can vary based on your insurance company and where you live. You should check your policy documents to understand what you're protected against.

What's not covered by dwelling insurance?

Most dwelling insurance policies don't protect your home from flooding, earthquakes or sinkholes.

In addition, standard dwelling insurance doesn't typically cover:

- Construction defects
- Foundation damage due to settling
- Homes under construction
- Infestation
- Sewer backup
- Vacant homes
- Wear and tear

However, many insurance companies give homeowners the option to add protection against some of these events.

Other structures

Detached garages, sheds or other such structures are not considered part of your dwelling under a traditional homeowner's policy. Instead, they're usually protected by your policy's other structures coverage, also known as Coverage B.

Those structures won't typically be covered by a condo policy since you probably aren't the sole owner of that property.

How much dwelling coverage do I need?

You should choose a dwelling coverage amount based on the amount it would cost to rebuild your home and its attached structures if they were totally destroyed.

This amount is not the same as the price you paid for the home or its current market value. The replacement cost of your home will depend on a number of factors, which include:

- The cost of construction and labor in your area
- The square footage of your home
- The style of house (such as a ranch or colonial home)
- Any custom-built features
- The materials used to build your home (like carpet or wood flooring)

Your insurance company will ask you lots of questions about your home when you get a quote, which will help determine how much dwelling coverage you need.

A professional appraiser can give you the most accurate estimate of your home's replacement cost, but you'll have to pay for their services. This might be worth the effort if you feel the insurance company's estimate is too high or too low.

Extra coverage options

Most major homeowners' insurance companies give homeowners the ability to add extra coverage to their dwelling insurance. This extra protection is called an endorsement, rider or floater.

You might want to consider this if your home is at risk of being damaged by something that's not typically covered.

Common dwelling insurance endorsements

- Earthquake coverage
- Flood insurance
- Inflation guard
- Sinkhole coverage
- Water backup coverage

How much does dwelling coverage cost?

Dwelling insurance accounts for 95% to 97% of your total insurance cost. It is the most expensive part of your homeowner's insurance policy.

What does dwelling coverage cover?

Dwelling insurance covers your home's structure, including your foundation, walls, roof and all of the permanent fixtures inside of your home. It also protects any attached structures, like an attached garage or deck.

How much dwelling insurance do I need?

Homeowners should choose a dwelling insurance limit that would cover the cost of fully rebuilding their home in a major disaster. You can figure out your home's replacement value using your insurance company's software, but hiring a professional appraiser will get you the most accurate estimate.

How important is dwelling coverage?

Dwelling coverage is very important because it will help pay to repair or rebuild your home if it's damaged in a covered event, like a fire or windstorm. If you have a mortgage on your home, your lender will usually require you to have a minimum amount of dwelling coverage. Even if your home is paid off, dwelling coverage can help you avoid expensive repairs if your home has major damage.

What coverage is excluded by a dwelling policy?

Home insurance policies typically exclude earthquakes, flooding and sinkholes. Your home insurance company generally won't pay for repairs due to general wear and tear. There are a number of other types of damage that are usually excluded from your dwelling coverage like damage while your home is under construction or vacant.

What does dwelling mean?

Your dwelling is the house or apartment where you live. In terms of insurance, your dwelling includes the structure of your home — like the floor, walls and windows — along with any attached structures, like a garage.

C. Commercial Lines

Definition: Commercial lines refer to insurance policies designed for businesses, covering various risks such as property damage, liability, and employee-related risks.

1. Commercial Package Policy (CPP)

Definition: A Commercial Package Policy (CPP) is a customizable insurance policy that combines multiple coverages, such as property and liability, into a single policy.

Example: A small manufacturing company purchases a CPP that includes general liability coverage, property insurance, business income insurance, and equipment breakdown coverage.

2. Commercial Property

Definition: Commercial property insurance covers damage to buildings and personal property used in business operations.

Example: A retail store's commercial property insurance covers damage to the store's building and inventory due to a fire.

a. Commercial Building and Personal Property Form

Definition: This form covers direct physical damage to buildings and personal property used in business operations.

Example: A restaurant's policy covers damage to the building and kitchen equipment due to a burst pipe.

b. Causes of Loss Forms

Definition: These forms specify the perils or causes of loss that are covered under a commercial property insurance policy.

Example: A policy may include causes of loss such as fire, theft, and windstorm.

c. Business Income

Definition: Business income insurance, also known as business interruption insurance, covers lost income and extra expenses when a business cannot operate due to a covered loss.

Example: A bookstore's business income insurance covers lost revenue and extra expenses for temporary relocation after a fire.

d. Extra Expense

Definition: Extra expense insurance covers additional costs a business incurs to continue operations after a covered loss.

Example: A tech company's extra expense insurance covers the cost of renting temporary office space and equipment after a flood.

e. Equipment Breakdown

Definition: Equipment breakdown insurance covers losses due to the mechanical or electrical failure of machinery and equipment.

Example: A bakery's equipment breakdown insurance covers the cost of repairing a broken oven.

3. Businessowners Policy (BOP)

Definition: A Businessowners Policy (BOP) bundles property and liability coverage into a single policy, typically for small to medium-sized businesses.

Example: A small consulting firm purchases a BOP that includes property insurance, general liability coverage, and business income insurance.

4. Builders Risk

Definition: Builders risk insurance covers buildings under construction against damage from events like fire, theft, and vandalism.

Example: A construction company's builders risk policy covers a partially built office building during construction.

5. Cyber First-Party Coverage

Definition: Cyber first-party coverage provides protection for a business's own losses due to a cyber event, such as data breaches or cyberattacks.

Example: An e-commerce company's cyber first-party coverage covers the costs of notifying customers and providing credit monitoring services after a data breach.

D. Inland Marine

1. Personal Articles Floaters

Definition: Provides coverage for personal property that is movable or in transit.

Example: Covers valuable items like jewelry or artwork while they are being transported.

A typical homeowners policy limits coverage for certain personal items up to $1,500, but what happens if your damaged or stolen items are worth more than that? If you have high-value items in your home, you may want to ensure that you're covered for the full cost of those items by purchasing a Personal Articles Floater (PAF) policy.

What is A Personal Articles Floater (PAF)?

A PAF is a type of insurance policy designed to provide additional coverage for your valuable personal items that typically exceed the limits of standard homeowners or renters' insurance policies. It offers protection against loss, damage, or theft for a range of high-value items.

Unlike the basic property insurance that often comes with a deductible and certain limitations, PAFs usually have no deductible, meaning that in the case of a successful claim, you'll receive the full dollar amount that you and your insurance company agreed upon at the start of the policy. This specialized coverage ensures that your most treasured items are protected, often worldwide, under a wide array of circumstances.

What types of personal property do PAFs cover?

PAF policies can cover a diverse array of personal property that might be extraordinarily valuable or not covered under standard insurance policies. Common items typically insured under a floater policy include:

- Jewelry and engagement rings
- Art and antiques
- High-end electronics
- Musical instruments
- Cameras and photography equipment
- Stamp or coin collections
- Sporting equipment
- Furs

If you have personal belongings that carry significant financial or sentimental value, a PAF may be an important consideration for ensuring those items are protected.

Do you need a PAF policy?

Determining whether you need a PAF depends on several factors, including the value of your possessions and their coverage under existing policies. If your homeowners or renters' insurance doesn't fully cover high- value items, or if you require expanded protection (e.g., coverage during travel), then investing in a floater might be a wise choice.

To decide if this insurance suits your needs, conduct a home inventory and have your valuables appraised to ascertain their current market value.

Understanding the limitations of your standard insurance will also help guide your decision. Reach out to your insurance agent to learn more about what your standard insurance covers.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS 

How much does a PAF cost?

The cost of a PAF varies based on several factors, including the overall worth of the insured items, your location, chosen coverage options, and the insurance company's policies. Premiums are usually determined based on a percentage of the item's appraised value, with more expensive items generally commanding higher insurance rates.

To get the best rate, it's a good idea to shop around and compare quotes from multiple insurers. It's also crucial to regularly reassess the value of your items and your policy to ensure continued adequate coverage as market values change.

What are my coverage options?

When choosing coverage options, consider the full breadth of protection you require. Policies can differ by insurance providers but often include:

- **All-Risk Coverage:** Protects against all potential causes of loss, except those specifically excluded in the policy.
- **Agreed Value Coverage:** Pays out the full agreed-upon amount of the item as listed in the policy if a total loss occurs.
- **Replacement Cost Coverage:** Reimburses you the cost of buying a new item of similar type and quality without depreciation.
- **Scheduled Items Coverage:** You individually list each valuable item along with its appraised value in the policy for specific coverage.

Policies can often be tailored to fit individual needs, ensuring that each of your possessions is protected according to its unique characteristics and risks.

What are my other options?

Apart from purchasing a floater policy, other options include increasing the coverage limit on your existing homeowners or renters' insurance or opting for specified perils coverage, which protects against specific risks named in the policy. Additionally, some credit cards offer protection for purchases, including personal property, but this is typically less robust than what a floater policy offers.

It's also worth noting that careful handling and storing of valuable items, as well as investing in security measures for your home, can complement the financial protection insurance provides.

How do I get started with PAF coverage?

Make a list of your valuable items and assign them a value, gathering an appraisal or receipt on those items if you're unsure. Get a quote from your insurance agent and determine whether increasing your homeowner's liability coverage or adding PAF insurance is more cost effective.

Remember to review your policy periodically and update coverage as necessary to reflect any new acquisitions or changes in value.

2. Commercial Property floaters

E. National Flood Insurance Program (NFIP)

Definition: A federal program providing flood insurance to property owners, renters, and businesses in participating communities.

Example: Covers flood damage to a home located in a high-risk flood area.

The National Flood Insurance Program (NFIP) is managed by the FEMA and is delivered to the public by a network of more than 50 insurance companies and the NFIP Direct.

Floods can happen anywhere — just one inch of floodwater can cause up to $25,000 in damage. Most homeowners' insurance does not cover flood damage. Flood insurance is a separate policy that can cover buildings, the contents in a building, or both, so it is important to protect your most important financial assets — your home, your business, your possessions.

The NFIP provides flood insurance to property owners, renters and businesses, and having this coverage helps them recover faster when floodwaters recede. The NFIP works with communities required to adopt and enforce floodplain management regulations that help mitigate flooding effects.

Flood insurance is available to anyone living in one of the almost 23,000 participating NFIP communities. Homes and businesses in high-risk flood areas with mortgages from government-backed lenders are required to have flood insurance.

F. Others

1. Earthquake

Definition: Provides coverage for damage caused by earthquakes.

Example: Covers structural damage to a home caused by an earthquake.

2. Mobile Homes

Definition: Specialized insurance for mobile or manufactured homes, covering risks unique to these types of homes.

Example: Covers damage from windstorms or fires specific to mobile homes.

If you own a prefabricated home — mobile or manufactured — you can get special homeowners' insurance that helps cover the risks unique to your home. In disasters like windstorms or fires, this type of insurance could help you protect yourself against loss if your home, your belongings or other structures on your property are damaged or destroyed.

What does mobile and manufactured home insurance typically cover?

Homeowners' coverage for mobile homes — those built in a factory and moved to their site — is similar to coverage for site-built homes, typically providing coverage for the physical structure, personal belongings and other structures on your property. This coverage may also include liability insurance, which helps you protect your finances if you're responsible for damage or injury to someone else or their property.

Typical mobile home insurance policies offer coverage for damage caused by:

- An aircraft, car or other vehicle
- Explosions

- Falling objects
- Fire and smoke
- Lightning strikes
- Theft
- Vandalism and malicious mischief
- Some types of water damage
- Windstorms and hail

But policies for mobile or manufactured homes vary in the details. For example, although most mobile and manufactured homes stay in the same place for their lifetime, they're designed to be movable. So, some manufactured home policies can include coverage for damage incurred during a move.

Because manufactured homes may be more likely to suffer damage from incidents like fire and wind, mobile and manufactured home insurance policies are designed specifically for these types of structures. In addition, some insurers may require that a mobile or manufactured home be placed on a concrete or cinderblock foundation to be insured.

What are the different types of insurance coverage for mobile and manufactured homes?

Insurance for mobile and manufactured homes is much like regular **homeowners' insurance** and can provide the same main types of coverage:

Dwelling coverage helps you pay to repair or rebuild your manufactured home when it's damaged or destroyed in an insurance- covered event, like a windstorm or fire.

Personal property coverage helps you pay to fix your belongings if they're damaged or buy new ones if they're ruined or stolen.

Liability coverage helps you protect your financial assets if you're at fault for someone's injury or property damage.

How much insurance do I need for my manufactured or mobile home?

If you have a mortgage, your lender will likely require you to carry enough mobile and manufactured home insurance to cover at least the mortgage's remaining balance. This may not be enough to cover other losses. When deciding how much coverage you want, you may want to consider other factors, including:

- The cost of rebuilding your home
- The value of your belongings, like clothing, appliances and furniture
- The total value of your assets
- The cost to live elsewhere if damages make your home unlivable If you live in an area prone to **earthquakes** or **floods**, you may want to consider adding additional coverage, because your standard policy may not cover these hazards.

How much does mobile and manufactured home insurance cost?

Characteristics of your home, hazards in your area and how much coverage you want are the main factors that will influence how much you pay for mobile or manufactured home insurance — just as with regular homeowners' insurance. Among the relevant factors:

- Your home's age, size and how it's built
- The risks inherent in its location — things like extreme weather, flooding, high winds, crime
- How much your possessions are worth
- Whether you rent or own your home's lot
- Security and safety features
- The coverage limits and deductible that you choose
- Your mobile home's claims history

Keep in mind, insurance premiums for a mobile or manufactured home may be more expensive than regular homeowners' insurance, because of their increased vulnerability to common risks, such as fire and wind.

What is the difference between mobile and modular home insurance?

Modular homes are similar to mobile and manufactured homes in that they're built inside factories. But modular homes are built in pieces, transported to a building site and assembled on a permanent foundation. Their construction must follow all state and local building and safety codes, and they typically can be insured with a standard **homeowners insurance policy**.

Note that while the term mobile home is sometimes used interchangeably with the term RV, **recreational vehicles need their own kind of insurance** because they are motorized vehicles with homes attached.

Mobile homes are technically factory-built homes built before June 15, 1976. After that date, new federal building and safety standards kicked in and the name shifted to manufactured homes. The standards require manufactured homes to be constructed on a permanent chassis.

What Does Recreational Vehicle Insurance Cover?

RV insurance policies cover direct and accidental physical damage to a motor home, including permanently installed accessories such as: awnings, antennas and satellite dishes. The range includes — but isn't limited to — collision, lightning, flooding, landslides, wind and hail, wild animals, fire and smoke, vandalism and theft, and trees and overhangs.

A standard RV insurance policy may help with potential risks like these:

- A low-hanging branch causes damage
- As you're pulling into the campground, a low-hanging branch damages your satellite dish and cracks a skylight.
- You don't see an obstacle behind you

- While backing your RV into a parking spot, you don't see low concrete poles protecting the water hookup. The collision leaves your motor home with a crumpled bumper and broken spare tire cover.
- Your motor home has flood damage
- You're parked next to a river that floods unexpectedly after a heavy rainstorm — leaving your motor home sitting in three feet of water.

You can also customize your RV insurance coverage with a number of options:

Total Loss Replacement coverage can help if your new motor home is declared a total loss within the first five years — providing a brand new replacement of a similar kind and quality.

Emergency Expense coverage can help with the cost of lodging or travel if your motor home is damaged more than 50 miles from home.

Campsite/Vacation Liability coverage can help when a motor home is parked and used as a vacation residence.

Replacement Cost coverage can help if personal belongings are destroyed or stolen.

Towing and Roadside Assistance can help with towing, tire changes, fluid delivery and locksmith services.

Full-Timer coverage can help with personal liability protection when your motor home is parked and used as a dwelling for an extended period of time.

3. Watercraft Insurance

Definition: Provides coverage for boats and other watercraft, including liability and physical damage.

Example: Covers damage to a boat from a collision.

What Is Watercraft Insurance?

Watercraft insurance is an umbrella term for three types of insurance: boat insurance, yacht insurance, and personal watercraft insurance. It protects against damage to vessels powered by a motor that has a horsepower of at least 25 miles per hour (mph). Examples of the types of costs covered by watercraft insurance policies include physical loss or damage to the boat, theft of the boat, and towing.

Key Takeaways

Watercraft insurance is an umbrella term for three types of insurance:

- boat insurance, yacht insurance, and personal watercraft insurance.

The type of coverage you buy is dictated by the size of your vessel.

Although watercraft insurance is not required in many states, many boat owners choose to purchase it anyway.

Boat-loan providers and marinas often require boat owners to have watercraft insurance.

How Watercraft Insurance Works

Depending on the policy, there may also be watercraft liability coverage for bodily injury to people other than the boat's owner and family, guest passengers using the boat by themselves, and medical payments for injury to the owner and their family. Some policies, however, require the purchase of additional liability coverage as an add-on. The specific type of insurance you buy is dictated by the size of your vessel.

Watercraft insurance is similar to other types of insurance products. In exchange for paying a series of insurance premiums, the policyholder receives protection from certain rare but potentially costly risks. Depending on factors such as the size of the craft, its age, and its intended uses, the premium costs may range from relatively inexpensive to pricey. When underwriting a policy, an insurance company will also consider the policyholder's track record of previous claims.

Boat Insurance

Any vessel under 197 feet long is considered a boat, while ships are 197 feet or longer. The dividing line between boat and yacht is less settled.

Some sources define a yacht as at least 30 feet long. Anything shorter is a pleasure boat.

For insurance purposes, the National Boat Owners Association marks the dividing line at 27 feet.

Small craft, such as canoes, rowboats, small sailboats, and powerboats with less than 25 miles-per-hour horsepower may be covered under a standard homeowners or renter's insurance policy. However, such coverage is unlikely to include liability insurance. Typical boat insurance covers theft; physical damage to the boat itself due to a collision or striking a submerged object; property damage to the boat caused by vandalism, a windstorm, or lightning; and medical payments for injured passengers and the owner and their family. For each coverage, there will be different deductibles, which is how much you must pay out of pocket before your insurance kicks in. Boat insurance will often provide better liability insurance than a homeowners policy, but it is often wise to purchase additional liability coverage as an add-on.

In the event of a total loss, it is important to know whether your policy pays actual cash value (ACV) or agreed value (AV). ACV is cheaper because it only pays for what the boat was worth at the time of the loss, factoring in depreciation and wear and tear on the vessel. AV pays a price that you and your insurer agree upon in advance, an amount that is likely to be closer to the amount you paid for the boat when new.

Other considerations for boat insurance can include:

- **Lay-up period**—This covers your boat for property damage during the off-season, when it isn't in the water.
- **Navigational territory**—Your insurance will generally specify where you can go in your boat and still be covered.
- **Property damage**—This is for damage your boat inflicts on someone else's property.
- **Hurricane haul-out provisions**—This covers your costs of getting the boat out of harm's way before a windstorm.
- **On-water towing and assistance**—This is for unexpected breakdowns or running aground.

- **Fuel spill liability protection**—Should there be an accidental discharge of fuel from your boat, this will cover the costs of a clean-up.
- **Personal effects coverage**—This will protect any expensive equipment you have on your boat, such as fishing gear
- **Ice and freeze coverage**—Should cold weather damage your boat's engine and water systems, this will pay the bill.

Yacht Insurance

Most yacht coverage is broader and more specialized than pleasure boat coverage because larger vessels travel farther and are exposed to greater risks. It also generally costs more, in part because yachts cost more. In terms of a deductible, it is usually determined as a percentage of the insured value. With a 1% deductible, a boat insured for $175,000 would have a $1,750 deductible. Most lenders allow a maximum deductible of 2% of the insured value.

Generally, yacht insurance coverage does not include wear and tear, gradual deterioration, marine life, marring, denting, scratching, animal damage, osmosis, blistering, electrolysis, manufacturer's defects, defects in design, and ice and freezing.

There are two main parts of a yacht insurance policy: hull insurance and protection and indemnity (P&I). The first is an all-risk, direct damage coverage that includes an AV for hull coverage, and in the case of a total loss, it will be paid out in full. Replacement cost coverage on partial losses is also available. However, sails, canvas, batteries, outboards, and sometimes outdrives are usually subject to depreciation instead.

P&I insurance is the broadest of all liability coverages, and because maritime law is particular, you will need coverages that are designed for those exposures. Longshore and harbor workers' coverage and Jones Act coverage (for the yacht's crew) are included and are important because your losses in these areas could run into six figures. P&I will cover any judgments against you and also pay for your defense in admiralty courts.

Personal Watercraft Insurance

Personal watercraft insurance is for recreational vehicles such as Jet Skis, Sea-Doos, and Yamaha Wave Runners. These surface-skimming craft can have engines with horsepower anywhere from 60 mph to 310 mph. They usually are not covered by homeowners' insurance, and even when they are, the coverage limits are low.

Personal watercraft insurance covers the owner and anyone they allow to use the craft for risks such as:

- Bodily injury to another person
- Bodily injury to you that is caused by an uninsured watercraft operator
- Liability in the form of legal costs if you're sued due to an accident (which can include water sports liability for things such as waterskiing risks)
- Property damage to another watercraft, a boat, or a dock
- Theft
- Towing after an accident

Deductibles and liability limits will vary depending upon the policy and the company offering it. You can buy additional coverage for trailers and accessories and, if you own more than one

craft, you may be able to bundle your insurance policies for a discount. These pleasure vehicles are easy to use but can also be dangerous, causing thousands of injuries every year, which makes personal watercraft insurance a wise investment.

Watercraft insurance policies may limit the geographic areas in which the boat or watercraft can be operated while maintaining coverage. These often include inland waterways, rivers, and lakes, as well as ocean waters within a certain number of miles from shore.

Do I Need Watercraft Insurance?

Only a few states make it mandatory for boat owners to obtain watercraft insurance. However, many owners will opt to purchase it regardless, partly because doing so is required in order to obtain a boat loan. Marinas may also require owners to have watercraft insurance as a condition within their rental agreements.

Even if your craft isn't worth much money, obtaining watercraft insurance is a good idea because of the risk of injury on the water, especially from a collision. Even if you aren't at fault, you could spend a lot of money in legal fees defending yourself—much more than your insurance premiums. If you do decide to purchase this insurance, make a point of comparing policies from multiple companies before deciding on which is best for you. As with all insurance, the question is what price you put on having peace of mind.

4. Farm Owners

1. Type of Property Covered

Reason: Farm insurance covers a wider range of property, including farm buildings, equipment, livestock, and crops.

Example: A farm insurance policy covers damage to a barn, tractors, and harvested crops, whereas a homeowner's policy would not cover these items.

2. Business vs. Personal Use

Reason: Farm insurance is designed to cover both personal and commercial risks associated with farming operations.

Example: A farm insurance policy covers liability for farm activities, such as a visitor getting injured while touring the farm, which a homeowner's policy would not cover.

3. Higher Value of Property

Reason: Farm properties often have higher-value equipment and structures compared to typical homes.

Example: A farm insurance policy covers high-value equipment like combine harvesters and irrigation systems, which are not typically found in a residential setting.

4. Exposure to Unique Risks

Reason: Farms face unique risks such as crop failure, livestock disease, and natural disasters specific to agricultural operations.

Example: A farm insurance policy covers losses due to drought affecting crop yield, which a homeowner's policy would not address.

5. Liability Coverage

Reason: Farm insurance provides broader liability coverage for farm-related activities and potential claims.

Example: A farm insurance policy covers liability for injuries caused by farm animals, such as a guest being injured by a horse, which a homeowner's policy would not cover.

6. Additional Coverage Options

Reason: Farm insurance offers specialized coverage options tailored to agricultural needs.

Example: A farm insurance policy includes coverage for equipment breakdown, which is essential for maintaining farm operations, whereas a homeowner's policy does not offer this coverage.

7. Regulatory Requirements

Reason: Farm insurance may be subject to different regulatory requirements and standards compared to homeowners' insurance.

Example: Certain states may require specific coverage for farm operations that are not necessary for residential properties.

These differences highlight the unique needs and risks associated with farming, necessitating specialized insurance coverage.

Let's dive deeper into the differences between farm insurance and homeowners' insurance, with more detailed explanations and examples for each point.

1. Type of Property Covered

Farm Insurance:

- **Definition:** Covers a wide range of properties associated with farming, including outbuildings (barns, silos), machinery, livestock, crops, and personal property.
- **Example:** Farm insurance covers a barn, tractors, harvested crops, and livestock in case of a fire.

Homeowners Insurance:

- **Definition:** Primarily covers the dwelling, personal property, and detached structures (like a garage or shed) within a residential setting.
- **Example:** Homeowners insurance covers the house, personal belongings, and a detached garage if damaged by a storm.

2. Business vs. Personal Use

Farm Insurance:

- **Definition:** Designed to cover both personal and commercial activities related to

farming.

- **Example:** A farm policy covers liability if a visitor is injured while touring the farm, in addition to covering the farmer's home and personal property.

Homeowners Insurance:

- **Definition:** Primarily for personal use and typically excludes coverage for business activities.
- **Example:** Homeowners insurance covers the homeowner's personal property and liability within their residence, not for any business conducted from home.

3. Higher Value of Property

Farm Insurance:

- **Definition:** Covers high-value agricultural equipment and structures which are essential for farming operations.
- **Example:** Farm insurance covers high-value machinery like combine harvesters and irrigation systems.

Homeowners Insurance:

- **Definition:** Covers the typical range of personal property and home structures, which generally have a lower value compared to farm equipment.
- **Example:** Homeowners insurance covers personal property like furniture and electronics.

4. Exposure to Unique Risks

Farm Insurance:

- **Definition:** Addresses specific agricultural risks such as crop failure, livestock disease, and specific natural disasters (e.g., drought).
- **Example:** Farm insurance covers losses due to a drought affecting crop yield.

Homeowners Insurance:

- **Definition:** Covers common residential risks like fire, theft, and personal liability.
- **Example:** Homeowners insurance covers damage caused by a fire in the home.

5. Liability Coverage

Farm Insurance:

- **Definition:** Provides extensive liability coverage for farm-related activities and potential legal claims arising from farming operations.
- **Example:** Farm insurance covers liability for injuries caused by farm animals (e.g., a guest injured by a horse).

Homeowners Insurance:

- **Definition:** Offers liability coverage within the residential context, mainly for personal activities and property.
- **Example:** Homeowners insurance covers liability if a guest slips and falls in the homeowner's kitchen.

6. Additional Coverage Options

Farm Insurance:

- **Definition:** Offers specialized coverage tailored to agricultural needs, such as livestock insurance, crop insurance, and equipment breakdown coverage.
- **Example:** A farm policy includes coverage for livestock against disease and equipment breakdown for essential machinery.

Homeowners Insurance:

- **Definition:** Provides standard additional coverages like personal property replacement and extended dwelling coverage but lacks specialized agricultural options.
- **Example:** Homeowners insurance offers an endorsement for high-value items like jewelry but does not cover farm-specific needs.

7. Regulatory Requirements

Farm Insurance:

- **Definition:** May be subject to different regulatory standards and requirements to meet the unique needs of agricultural operations.
- **Example:** Certain states require specific coverage for farm operations that ensure comprehensive protection for agricultural businesses.

Homeowners Insurance:

- **Definition:** Adheres to standard residential property insurance regulations focused on personal and family protection.
- **Example:** Homeowners policies are regulated to ensure coverage for typical residential risks and personal liabilities.

These detailed explanations and examples highlight the unique aspects of farm insurance compared to homeowners' insurance, emphasizing the need for specialized coverage to address the specific risks and properties associated with farming.

5. Windstorm Insurance

Definition: Provides coverage for damage caused by windstorms, including hurricanes and tornadoes.

Example: Covers roof damage from a hurricane.

What Is Windstorm Insurance?

Windstorm insurance is a special type of property-casualty insurance that protects policyholders from property damage caused by gales, winds, hail, and other gusty hazards. A subset of storm insurance, windstorm insurance is usually offered as a rider on a standard casualty insurance policy through the extended coverage endorsement.

Key Takeaways

Windstorm insurance protects policyholders from property damage caused by gusty events, such as tornadoes, hurricanes, and gales.

Windstorm insurance will typically cover physical damages to the property and personal belongings.

Windstorm coverage is typically affixed as a rider to a homeowners insurance policy.

Many policies limit the time frame to file a claim for windstorm damage.

How Windstorm Insurance Works

Windstorm insurance covers the types of excessively gusty events, such as hurricanes and cyclones, that are often considered vis major and so might be excluded from standard homeowners' insurance policies.

Those who live in areas susceptible to this type of peril must purchase this additional coverage to protect themselves. Residents of coastal and midwestern states, where hurricanes and tornadoes are relatively common, fall into this category.

If you have a mortgage loan and live in a high-risk area for windstorms, your mortgage lender may require you to purchase windstorm insurance.

What's Covered

Windstorm insurance will typically cover physical damage to the property and personal belongings inside the home. Many policies also include coverage for detached structures, such as garages and sheds. When big winds harm roofs and windows, rain and debris can cause additional damage. In such cases, most policies will cover repairs as long as the claim is filed soon after the event.

What's Not Covered

Sometimes, windstorms are followed by storm surges and flooding, but windstorm insurance will not typically cover damage caused by these rising waters. Flood insurance coverage provided by the federal government must be purchased separately, and it takes 30 days to go into effect.

Neither windstorm insurance nor homeowners' insurance will cover repairing or replacing a vehicle damaged by a wind-toppled tree or other blowing debris. You must carry a comprehensive auto insurance policy to cover a car.

Filing a Windstorm Insurance Claim

To file a windstorm insurance claim, you must take certain steps. The most important thing is to act quickly. Many policies limit the time frame to file a claim for storm damage. Often, this is because failure to fix problems promptly can lead to more damage later.

Immediately after a windstorm, a windstorm insurance policyholder should:

- Record the storm date and save news articles about the storm as proof.
- Assess and record all damage that they see from the ground with pictures and/or video.
- Have at least two reputable contractors inspect the property and provide written estimates for repairs.

- Contact the claims department of their insurance carrier, provide all the information they have gathered, and request a visit from a claims adjuster.
- Ask one of the contractors to be present during the insurance adjuster's inspection to ensure a fair assessment.
- If a claim is denied, request another evaluation. Policyholders are entitled to meet with three different insurance adjusters.

What Is the Difference Between Homeowners Insurance and Windstorm Insurance?

Homeowners insurance protects you financially from structural damage to your property, theft or damage to personal belongings, and liability.

Homeowners insurance may cover wind damage due to hurricanes, but it may not cover a high-risk area like along the coast for wind damage. As a result, you would need windstorm insurance if your home is in a coastal area.

Are You Required to Get Windstorm Insurance?

Typically, you are not required to get windstorm insurance. However, if you live in a coastal area prone to wind damage and have a mortgage loan, your mortgage lender may require you to buy windstorm insurance.

How Much Does Windstorm Insurance Cost?

Windstorm insurance can cost approximately $2,000 per year in coastal or high-risk areas. However, the cost can vary depending on the size of the home, its location, and the insurer.

The Bottom Line

Windstorm insurance covers excessively gusty events, including hurricanes and cyclones, often excluded from a homeowners insurance policy. Those living in high-risk areas must purchase windstorm insurance in addition to their homeowner's insurance. However, storm surges and flooding that follow a windstorm and cause property damage may not be covered by windstorm insurance.

II. PROPERTY: INSURANCE TERMS AND RELATED CONCEPTS

A. Insurance

Personal lines insurance refers to insurance policies designed to protect individuals and their families from financial losses due to various personal risks. These risks can include damage to property, theft, natural disasters, accidents, illness, and even death. Here are some key points about personal lines insurance:

- **Coverage Types**: Personal lines insurance includes a variety of policies such as:
- **Homeowners Insurance**: Protects against damage to your home and personal property, as well as liability for accidents that occur on your property.

- **Auto Insurance**: Covers damages and liabilities related to car accidents.
- **Renters Insurance**: Provides coverage for personal belongings and liability for renters.
- **Life Insurance**: Offers financial protection to beneficiaries in the event of the policyholder's death.
- **Health Insurance**: Covers medical expenses for illnesses and injuries.
- **Disability Insurance**: Provides income replacement if you are unable to work due to a disability.
- **Umbrella Insurance**: Offers additional liability coverage beyond the limits of other policies.

Purpose: The main goal of personal lines insurance is to protect individuals from financial ruin by covering significant losses that they might not be able to afford on their own[1][2].

Customization: Policies can often be tailored to meet the specific needs and budget of the individual. This includes adjusting coverage limits, deductibles, and premiums.

Legal Requirements: Some types of personal lines insurance, like auto liability insurance, are often required by law[1].

1. Law of Large Numbers

Definition: The Law of Large Numbers states that as the number of exposure units (e.g., policyholders) increases, the actual loss per unit will more closely approximate the expected loss per unit.

Example: An insurance company can predict the number of claims it will receive more accurately if it insures 10,000 homes rather than just 100 homes.

The Law of Large Numbers in the Insurance Industry

Insurance companies rely on the law of large numbers to help estimate the value and frequency of future claims they will pay to policyholders. When it works perfectly, insurance companies run a stable business, consumers pay a fair and accurate premium, and the entire financial system avoids serious disruption. However, the theoretical benefits from the law of large numbers do not always hold up in the real world.

Key Takeaways

The Law of Large Numbers theorizes that the average of a large number of results closely mirrors the expected value, and that difference narrows as more results are introduced.

In insurance, with a large number of policyholders, the actual loss per event will equal the expected loss per event.

The Law of Large Numbers is less effective with health and fire insurance where policyholders are independent of each other.

With a large number of insurers offering different types of coverage, the demand for variety increases, making the Law of Large Numbers less beneficial.

What is the Law of Large Numbers?

The law of large numbers stems from the probability theory in statistics. It proposes that when the sample of observations increases, variation around the mean observation declines. In other words, the average value gains predictive power.

For example, consider a simple trial in which someone flips a quarter. Every time the quarter lands on heads, the person records one point. No points are recorded when it lands as tails. The expected value of a coin flip in this trial is 0.5 points because there is only a 50% chance that the quarter will land as heads.

If you only flip the coin twice, the average value could end up far from the expected value. Consecutive heads produce an average value of one point while two tails have an average value of zero points. Increasing the number of observations is more likely to yield an average value closer to the expected value. If there are 53 heads and 47 tails during 100 flips, the average value would be 0.53, which is very close to the 0.5 expected value.

This is how the law of large numbers works.

Understanding the Law of Large Numbers in Insurance

In the insurance industry, the law of large numbers produces its axiom. As the number of exposure units (policyholders) increases, the probability that the actual loss per exposure unit will equal the expected loss per exposure unit is higher. To put it in economic language, there are returns to scale in insurance production.

In practical terms, this means that it is easier to establish the correct premium and thereby reduce risk exposure for the insurer as more policies are issued within a given insurance class. An insurance company is better off issuing 500 rather than 150 fire insurance policies, assuming a stable and independent probability distribution for loss exposure.

To see it another way, suppose that a health insurance company discovers that five out of 150 people will suffer a serious and expensive injury during a given year. If the company insures only 10 or 25 people, it faces far greater risks than if it can ensure all 150 people. The company can be more confident that 150 policyholders will collectively pay sufficient premiums to cover the claims from five customers who suffer serious injuries.

Special Considerations

There were nearly 5,965 insurance carriers in the United States as of 2019, according to the National Association of Insurance Commissioners.

Some carriers are more successful than others who provide the same or similar types of coverage. If there are increasing returns to scale in insurance, thanks to the law of large numbers, then why are there so many insurance companies rather than a few giants dominating the industry?

First, all insurance companies are not equally adept at the business of providing insurance. This includes maintaining operational efficiency, calculating effective premiums, and mitigating loss exposure after a claim is filed. Most of these features do not impact the law of large numbers.

However, the law of large numbers becomes less effective when risk- bearing policyholders are independent of one another. This is most easily seen in the health and fire insurance industries because diseases and fire can spread from one policyholder to another if not properly contained. This problem is known as contagion.

There are also potentially insurable risks for which the law of large numbers theoretically could be useful, but there are not enough potential customers to make it work. Consider trying to insure a city against the risk of nuclear or biological warfare. It would take thousands or millions of major cities paying premiums to offset the cost of one realized risk. There aren't enough cities in the world to make it work.

Finally, each insurance consumer has an individual risk preference, time preference, and price point for insurance. As the variety in demands increases, the potential benefit from the law of large numbers decreases because fewer people want similar types of coverage.

B. Insurable Interest

Definition: Insurable interest is a financial stake in the insured item or event, meaning the policyholder would suffer a financial loss if the insured event occurs.

Example: A homeowner has an insurable interest in their house because they would incur a financial loss if it were damaged or destroyed.

What Is Insurable Interest?

Insurable interest is a type of investment that protects anything subject to a financial loss. A person or entity has an insurable interest in an item, event, or action when the damage or loss of the object would cause a financial loss or other hardships.

To have an insurable interest a person or entity would take out an insurance policy protecting the person, item, or event in question. The insurance policy would mitigate the risk of loss if something happens to the asset—like becoming damaged or lost.

Key Takeaways

Insurable interest is the basis of all insurance policies linking the insured and owner of the policy.

Insurable interest can be an object which, if damaged or destroyed, would result in financial hardship for the policyholder.

To exercise insurable interest, the policyholder would buy insurance on the item or entity in question.

The policy must not create a moral hazard, in which a policyholder would have a financial incentive to allow or even cause a loss.

Insurable interest is an essential requirement for issuing an insurance policy that makes the entity or event legal, valid, and protected against intentionally harmful acts. People not subject to financial loss do not have an insurable interest. Therefore, a person or entity cannot purchase an insurance policy to cover themselves if they are not actually subject to the risk of financial loss.

Understanding Insurable Interest

Insurance is a method of pooled risk exposure that protects policyholders from financial losses. Insurers have created many tools to cover losses related to various factors such as automobile expenses, health care expenses, loss of income through disability, loss of life, and damage to property.

Insurable interest specifically applies to people or entities where there is a reasonable assumption of longevity or sustainability, barring any unforeseen adverse events. Insurable interest insures against the prospect of a loss to this person or entity.

For example, a corporation may have an insurable interest in the chief executive officer (CEO), and an American football team may have an insurable interest in a star, franchise quarterback. Further, a business may have an insurable interest in its c-suite officers but not its average employees.

Property Insurable Interest

Homeowners insurance compensates a policyholder who suffers a significant financial loss if a fire or other destructive force destroys his or her home. The homeowner has an insurable interest in the property; losing that home would create a catastrophic loss for the policyholder. It is reasonable for the homeowner to expect longevity regarding the ownership of the house. The homeowner is, therefore, insuring against the possibility that something unforeseeable causes damage.

A policyholder may buy property insurance for their own home but not the house across the street. Purchasing homeowners' insurance for a neighbor's house creates an incentive to cause damage to that house and collect the insurance proceeds. Appropriate underwriting would not create such a temptation, which represents a moral hazard, whereby parties have an incentive to allow or even affect a loss.

The Principle of Indemnity and Insurable Interest

The indemnification principle holds that insurance policies should compensate a policyholder for a covered loss, but losses should not reward or penalize holders. Indemnification suggests that insurers should design policies to cover the value of the at-risk asset appropriately.

Poorly conceived or designed policies create a moral hazard, which increases the costs to insurance companies and drives premiums to unsustainable levels for policyholders.

Real-World Example of Insurable Interest

Insurable interest is also necessary in life insurance, though this has not always been the case. There are cases where people have purchased life insurance policies for elderly acquaintances strictly because they expect that person's imminent death. Life insurance regulations have evolved to require a relationship in which the policy owner will suffer a financial loss in the event of the insured's death. Hardship may include immediate family members, more distant blood relatives, romantic partners, creditors, and business associates. The face value of life insurance policies must not exceed the human life value of the insured; otherwise, the indemnity principle would be violated, creating a moral hazard.

Also, a policy may not be written without the knowledge of the insured person. This was the case in September 2018 when a California couple was accused of committing three counts of insurance fraud in order to receive $1 million in life insurance benefits.

Husband and wife, Peter and Jin Kim purchased life insurance on one of Mr. Kim's clients and listed Mrs. Kim as the client's beneficiary niece. On a second policy, Mrs. Kim appeared as the sister of the policyholder. Mr. Kim, a licensed insurance agent, also did not inform the company that the client had a diagnosed terminal illness when he submitted the applications.

Is Insurable Interest Required for Insurance Policies?

Yes. Insurable interest is, essentially, proof that an individual or entity would experience financial or other hardships as the result of damage to or loss of an item or person. This is evaluated during the underwriting process to ensure this direct link. Such proof of insurable interest is required for all insurance policies.

What Is Moral Hazard?

A moral hazard is when someone with an insurance policy is incentivized to cause loss or damage in order to collect on the insurance. For instance, somebody who is terminally ill may seek a life insurance policy knowing it will payout when they pass away soon after acquiring it. Having insurable interest helps minimize moral hazard.

Why Can't I Take Out a Life Insurance Policy on Just Anybody?

Unless you have insurable interest, you cannot take out a life insurance policy on that individual. If so, you could essentially place bets on, or else profit from the death of otherwise random individuals. Family members and dependents are often justifiable as having insurable interest. So are business partners, borrowers, and key employees in certain cases.

C. Risk

Definition: Risk refers to the uncertainty regarding financial loss.

Pure Risk: Involves situations where there is only the possibility of loss or no loss (e.g., fire damage).

Speculative Risk: Involves situations where there is a possibility of either loss or gain (e.g., investing in stocks).

Example: Pure risk includes the risk of a house fire, while speculative risk includes the risk of investing in the stock market.

What Is Pure Risk?

Pure risk is a category of risk that cannot be controlled and has two outcomes: complete loss or no loss at all. There are no opportunities for gain or profit when pure risk is involved.

Pure risk is generally prevalent in situations such as natural disasters, fires, or death. These situations cannot be predicted and are beyond anyone's control. Pure risk is also referred to as absolute risk.

Key Takeaways

Pure risk cannot be controlled and has two outcomes: complete loss or no loss at all.

There are no opportunities for gain or profit when pure risk is involved.

Pure risks can be divided into three different categories: personal, property, and liability.

Many cases of pure risk are insurable.

Understanding Pure Risk

There are no measurable benefits when it comes to pure risk. Instead, there are two possibilities. On the one hand, there is a chance that nothing will happen or no loss at all. On the other hand, there may be the likelihood of total loss.

Pure risks can be divided into three different categories: personal, property, and liability. There are four ways to mitigate pure risk: reduction, avoidance, acceptance, and transference. The most common method of dealing with pure risk is to transfer it to an insurance company by purchasing an insurance policy.

Many instances of pure risk are insurable. For example, an insurance company insures a policyholder's automobile against theft. If the car is stolen, the insurance company has to bear a loss. However, if it isn't stolen, the company doesn't make any gain. Pure risk stands in direct contrast to speculative risk, which investors make a conscious choice to participate in and can result in a loss or gain.

Pure risks can be insured because insurers are able to predict what their losses may be.

Types of Pure Risk

Personal risks directly affect an individual and may involve the loss of earnings and assets or an increase in expenses. For example, unemployment may create financial burdens from the loss of income and employment benefits. Identity theft may result in damaged credit, and poor health may result in substantial medical bills, as well as the loss of earning power and the depletion of savings.

Property risks involve property damaged due to uncontrollable forces such as fire, lightning, hurricanes, tornados, or hail.

Liability risks may involve litigation due to real or perceived injustice. For example, a person injured after slipping on someone else's icy driveway may sue for medical expenses, lost income, and other associated damages.

Insuring Against Pure Risk

Unlike most speculative risks, pure risks are typically insurable through commercial, personal, or liability insurance policies. Individuals transfer part of a pure risk to an insurer. For example, homeowners purchase home insurance to protect against perils that cause damage or loss. The insurer now shares the potential risk with the homeowner.

Pure risks are insurable partly because the law of large numbers applies more readily than to speculative risks. Insurers are more capable of predicting loss figures in advance and will not extend themselves into a market if they see it as unprofitable.

1. Pure vs. Speculative Risk

Unlike pure risk, speculative risk has opportunities for loss or gain and requires the consideration of all potential risks before choosing an action. For example, investors purchase securities believing they will increase in value.

But the opportunity for loss is always present. Businesses venture into new markets, purchase new equipment, and diversify existing product lines because they recognize the potential gain surpasses the potential loss.

D. Hazard

Definition: A hazard is a condition that increases the likelihood or severity of a loss.

Example: Storing flammable materials in a home increases the risk of fire.

Peril vs. Hazard in the Insurance Industry: An Overview

The words "peril' and "hazard" may seem virtually synonymous but they mean very different things in the insurance industry.

A peril is a potential event or factor that can cause a loss, such as the possibility of a fire that could engulf a house.

A hazard is a factor or activity that may cause or exacerbate a loss, such as a can of gasoline left outside the house door or a failure to regularly have the brakes of a car checked.

Essentially, a hazard makes a peril more likely to occur or makes it worse.

Key Takeaways

A peril is a potential adverse event.

A hazard makes that event more likely.

Hazards are divided into three classifications: physical, moral, and morale.

Peril

Peril means danger, and it has a connotation of imminent danger. A rockslide is a peril to anyone standing underneath the cliff when the rocks start sliding.

In insurance contracts, the perils that are covered are usually specified. Fire, wind, water, and theft, are the perils that are commonly listed.

However, note that the language may indicate that the damage will not be covered in certain circumstances, such as if the insurance company finds that neglect by the insured caused the damage or made it worse.

This is the root cause of many disputes between insurer and insured. For example, the insurer may deny a claim for roof damage after a storm, citing owner neglect in not replacing an old roof.

In effect, the insurer is citing maintenance neglect as a hazard.

Hazard

Before deciding to provide coverage, an insurer may consider the particular hazards that make one candidate riskier than most others. A hazard may be any action, condition, habit, circumstance, or situation that makes a peril more likely to occur or a loss more likely to be suffered as the result of a peril.

The insurance industry commonly divides hazards into three categories: physical, moral, and morale.

1. Moral Hazards

Moral hazards are wrongful behavior or conduct.

Health insurance companies are concerned with moral hazards that lead to fraudulent claims, such as auto accident victims who invent or exaggerate their injuries.

The insurance industry itself may be a morale hazard. Having insurance may make people less careful about avoiding injury or illness since they have insurance to cover the costs.

A business owner who ignores health and safety concerns in the workplace has created a moral hazard. Failing to properly maintain business structures is a moral hazard.

2. Morale Hazards

Morale hazards are careless or reckless attitudes that can cause peril.

It has been speculated that the insurance industry itself causes a morale hazard. That is, an individual who is covered by insurance might be less likely to safeguard health or property than one who will lose everything if a disaster occurs.

Even the legal system is sometimes considered a morale hazard as it may encourage people to sue for monetary gain even when they have little or no cause.

3. Physical Hazards

Physical hazards are actions, behaviors, or conditions that cause or contribute to peril. Smoking is considered a physical hazard because it increases the chance of a fire occurring. It also is considered a physical hazard in regard to health insurance because it increases the probability of severe illness.

Frayed electrical wiring or liquid spills are physical hazards, as are a number of activities, such as working at high altitudes and operating heavy equipment.

E. Peril

Definition: A peril is a specific cause of loss or damage covered by an insurance policy.

Example: Fire, theft, and windstorms are common perils covered by homeowners' insurance.

What Is an Uninsurable Peril?

Uninsurable perils are events for which insurance coverage is not available or for which insurers are unlikely to underwrite policies.

An uninsurable peril is typically an event that has a high risk of occurrence, meaning the probability of a payout is high and expected. Perils that insurers are unwilling to cover are often catastrophic in nature.

Key Takeaways

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An uninsurable peril is typically an event with a high risk of occurrence.

Perils that insurers are unwilling to cover are often catastrophic in nature, for which the probability of a payout is high and expected.

The major areas for which insurance is unobtainable include reputational risk, regulatory risk, trade secret risk, political risk, and pandemic risk.

Understanding Uninsurable Perils

Uninsurable peril risk is relatively widespread across the human experience. An example of an uninsurable peril might be if an individual builds a home in a known flood area.

Because the area has a history of that particular peril, it is unlikely an insurance company will want to extend flood coverage because of the difficulty in managing the potential risk. That sort of difficulty managing the risk is the primary reason why flood insurance exists as a government program managed by the Federal Emergency Management Agency (FEMA) instead of as a subset of private insurance.

Types of Uninsurable Perils

While in no way a complete list, the major areas where insurance is unobtainable include reputational risk, regulatory risk, trade secret risk, political risk, and pandemic risk.

Reputational Risk

Reputational risk occurs when a company does something, or something happens to a company, that damages its public image to the point where its business is imperiled. For example, a CEO is involved in a sexual harassment scandal, or someone is randomly placing poison in bottles of a company's product.

There may be some coverage (for product recall expenses, for example). But generally, these situations cannot be insured because an insurer cannot determine what the risk is and what it's worth.

Regulatory Risk

Regulatory risk is the possibility a government agency will do something, or a government will pass a law that severely damages a business. For example, forcing coal-powered electric generators to close.

Thousands of new rules and laws are posted at the state, local, and federal levels every year. It's impossible for an insurer to anticipate these or write a policy to mitigate the damage to a company stemming from them.

Trade Secrets

Trade secrets are essential to many companies, yet if they are exposed or stolen the damage is hard to calculate. A hacker can steal key computer code. A disgruntled employee can walk off with secret formulas or processes.

Predicting how likely this is to happen, or the amount of damage is beyond the ability and scope of most insurers.

Political Risk

Political risks such as government expropriation of an asset, war or political violence, credit default of trade receivables, or when foreign governments block transfer of currency and assets, are difficult to insure against because they are so unpredictable.

Pandemic Risk

Extreme levels of unpredictability are also expected with pandemics. The effects of mass illnesses can vary widely. The pandemic-level flu H1N1 disrupted some businesses, but the viral infection COVID-19 profoundly disrupted the world economy.

Because of the unpredictability, scale, and cost involved in pandemic situations, private insurance can't help most people or businesses.

F. Loss

1. Direct Loss

Physical damage to property resulting directly from a peril.

Example: Fire damage to a building.

2. Indirect Loss

Financial loss resulting from the direct loss.

Example: Loss of rental income due to fire damage to a rental property.

G. Loss Valuation

Actual Cash Value (ACV): The cost to replace an item minus depreciation.

Example: If a five-year-old TV is destroyed, ACV would pay the current value of the TV, not the original purchase price.

What Is Actual Total Loss?

Actual total loss is a loss that occurs when an insured property is destroyed or damaged to such an extent that it can be neither recovered nor repaired for further use. Often, an actual total loss triggers the maximum settlement possible according to the terms of the insurance policy.

Actual total loss is also known as "total loss." Sometimes, people will refer to a piece of property that cannot be salvaged as "totaled."

Key Takeaways

Actual total loss, also known as "total loss," occurs when an insured property is totally destroyed, lost, or damaged to such an extent that it cannot be recovered.

In these cases, the insured party should qualify to receive a payout from the insurance company for the full insured value of the property.

There can be complications, though, and a maximum settlement is never guaranteed.

Settlement amounts also hinge on the type of coverage protecting the destroyed property.

Insurance companies lose money when paying out the total insurable value (TIV) and, as a result, won’t do so until they are completely satisfied that all terms have been met.

Understanding Actual Total Loss

Occasionally, property covered by insurance can become destroyed or damaged to such an extent that it can no longer be used or reasonably salvaged. Whether it was caused by theft, natural disaster, an accident of some sort, or something else, the insured party should qualify to receive a payout from the insurance company for the insured value of the property. The insurance provider determines the amount covered in a process known as ground-up loss.

Actual total loss can be contrasted with constructive total loss, which occurs when a property is technically only partly damaged but increasing damage seems unavoidable, or the property has still been rendered unusable and beyond fixing. In such cases, the cost for the repair of an item—a house, boat, or car—is deemed to be more than the current value of that item. As a result, the insurance company may also provide a payout for the insured value of the property.

Example of Actual Total Loss

Suppose there's a hurricane heading for the coast of North Carolina. Hurricane Widget is a Category 5 storm and has been causing storm surges up to 15 feet high as it travels up the coast. Unsurprisingly, it wipes out numerous houses, including one owned by Bob and Sharon. All that remains of Bob and Sharon's home is stilts on the beach, meaning the property qualifies as an actual total loss.

Nearby, three miles inland, Kevin and Julie are also impacted by Hurricane Widget. Their house flooded up to the attic and a tree came through the roof. Although the house is still mostly there, this would be considered a constructive total loss because the structure has been rendered unusable due to damage.

Limitations of Actual Total Loss

Bob and Sharon, and other victims of natural disasters, usually qualify to receive the full value of the insured property that was completely destroyed. However, there can be complications, and a maximum settlement is never guaranteed.

Insurance companies lose money when paying out the total insurable value (TIV) and, as a result, won't do so until they are completely satisfied that all terms have been met. Adjusters have the right to ask for proof of loss and will usually get the insured parties to compile a list of every item destroyed. Proving that the house was obliterated is relatively simple. Accounting for all the contents contained within it less so, particularly if receipts and all other evidence were destroyed by the hurricane.

Settlement amounts also hinge on the type of coverage protecting the destroyed property. In the case of an actual total loss, many people assume they will automatically receive the full amount outlined on the policy declarations page. What they fail to realize is that the key points summarized in the opening page refer to the maximum amount that can be paid.

A closer look at the document should reveal more details about the type of policy. Within the small print, the insurer might agree to cover the cost of replacing the item or fork out what is known as the "actual cash value" (ACV).

Actual Total Loss Methods

1. Actual Cash Value (ACV)

Actual cash value (ACV) is the depreciated value of the property at the time of the loss. In other words, it means the sum to be paid out reflects the amount that could be fetched for the item if it were to be sold secondhand or as-is.

In the case of an automobile, the ACV will consider its mileage, and everyday wear and tear to determine its worth.

This inevitably means that the insured will receive less than what they paid when purchasing the vehicle, potentially making it difficult for them to go out and buy a similar model.

Unsurprisingly, the most expensive premiums are often attached to the replacement cost rather than the actual cash value option.

2. Replacement Cost

As its name implies, replacement cost provides the insured with the necessary money to replace the item that was destroyed. Such payments can take a while to arrive and will generally be distributed only after the insured party has already purchased a replacement.

What Is Total Loss Car Insurance?

Total loss car insurance is a type of car insurance that gives you the right to coverage to help pay for a new vehicle if the cost to repair your vehicle is more than its actual cash value (ACV). Your car insurance company will consider the incident a total loss if the cost to repair your vehicle is more than its actual cash value (ACV). In this scenario, your car may be referred to as "totaled."

Total loss car insurance typically has collision and comprehensive coverages. If your car becomes totaled, your car insurance company will give you a settlement, which you can use to purchase a new car. If you have collision and comprehensive coverages, your insurance company will typically pay you the actual cash value of your car if it's totaled.

How Do You Get a New Car After a Total Loss?

If the cost to repair your car is more money than what the car is worth, it will typically be considered a “total loss" by your car insurance company. If you have the right kind of insurance coverage, your insurance company will pay you the actual cash value of your car. There are two main types of car insurance coverage: collision insurance and comprehensive insurance.

Collision protects your car in the event of a collision, while comprehensive covers acts of nature, such as hailstorms and falling trees.

There are several steps you must take to get a new car after a total loss:

- File a claim with your insurance company.
- An insurance adjuster will come from your insurance company to look at the damaged vehicle.
- If the adjuster determines that your car is totaled, the insurance company will calculate the actual cash value of your car—the amount it would have been worth had it not been damaged. If you have collision or comprehensive coverage, your insurance company will give you a check for this amount. (This is called the settlement.)
- If you still owe money on the car, the amount that you are entitled to will be sent to your lender first. If there is any money left over after you've paid off your car loan, your lender will send you a check. (If you don’t owe any money, you can use the remainder toward your new car purchase.)

How Do You Negotiate With Car Insurance Adjusters About a Total Loss?

Negotiating the best settlement for a totaled car is important because it can help you obtain the best deal on a totaled vehicle. Here are some steps you can take to negotiate the best loss settlement:

- If a claims adjuster decides that your car is totaled, you should be prepared to provide them with the sticker details that accompanied your car when you purchased it. (It should include a list of your vehicle's features.)
- Before the claims adjuster gives you their offer, you should have already prepared a counteroffer. You can do this by entering all of the information you have about your car on a website like www.nadaguides.com.
- The website will help you determine the value of your car (specifically, the retail value). When you make your counteroffer, you should be able to present a printed copy. of the estimated retail amount and the features used to determine the amount.
- You can also visit used car websites, such as autotrader.com and cargurus.com, to find cars that are for sale with similar features and mileage as your car.
- Each state has unique laws about when a vehicle is totaled. For example, some states use a total loss threshold, which can vary between 50% and 100%. If the total loss threshold is 70%, this means your car is declared a total loss if the damages are greater than 70% of its value.

How Do You Get More In Your Total Loss Vehicle Settlement?

The reality is that insurance companies lose money when they are forced to pay out a settlement. It is in their best interest to pay you the smallest amount reasonably possible for your damages. However, it is possible to negotiate your car's value with your insurance company after an accident.

Here are some steps you can take to get more from your vehicle settlement:

- Determine what you are selling to your car insurance company—do the necessary research to determine your car's retail value.
- Prepare your counteroffer.
- Determine the comparables in the area—you can use websites like autotrader.com and cargurus.com.
- Obtain a written settlement offer from the car insurance company.
- Make your counteroffer for your totaled car.

How Do You Dispute a Total Loss Vehicle Amount?

The first step you should take if you are unhappy with your auto insurance company's payout is to appeal the total loss. Most insurance companies have a process for appeals. Next, you should talk to the adjuster; most insurance companies will have you meet with one of their adjusters. You should have appraisals of your car prepared for this meeting. You might also consider hiring an independent adjuster.

Finally, if you are still not satisfied with the outcome, your last resort might be arbitration or hiring a lawyer.

Replacement Cost: The cost to replace an item with a new one of similar kind and quality.

Example: If a TV is destroyed, replacement cost coverage would pay for a new TV of similar kind and quality.

Actual cash value is not the same as the replacement cost value of an item.

Actual cash value is computed by subtracting depreciation from replacement cost, while depreciation is figured by establishing an expected lifetime of an item and determining what percentage of that life remains.

This percentage, multiplied by the replacement cost, provides the actual cash value. Some policies might include a recoverable depreciation clause, allowing the owner to claim the depreciated value and the replacement actual cash value.

Example of Actual Cash Value

As an example: a man purchased a television set for $3,000 five years ago and it was destroyed in a hurricane. His insurance company says that all televisions have a useful life of 10 years. A similar television today costs

$3,500. The destroyed television had 50% (five years) of its life remaining. The actual cash value equals $3,500 (replacement cost) times 50% (useful life remaining) or $1,750.

This concept is different from the book value used by accountants in financial statements or for tax purposes. Accountants use the purchase price and subtract the accumulated depreciation in order to value the item on a balance sheet. ACV uses the current replacement cost of a new item.

Actual Cash Value vs. Replacement Cost

Property insurance policyholders will usually prefer payment based on the replacement cost of damaged or stolen property because it compensates the policyholder for the actual cost of replacing property.

For instance, if a camera is stolen, a replacement cost policy will reimburse you the full cost of replacing it with a new camera of like kind. The insurer will not take into consideration that the lost camera had a shutter count of 25,000 because you used the camera every day for the last two years, causing a considerable amount of wear and tear.

3. Market Value:

The amount a buyer would pay for the property in its current condition.

Example: The market value of a house includes the value of the land and location.

What Is Fair Market Value?

Fair market value is the price that an asset would sell for under current market conditions, assuming that both the buyer and the seller are seeking the best possible price. The term is widely used in legal settings, where it may be difficult to set an objective value for some assets.

Fair market value (FMV) is similar to market value, the price that the asset would trade for in the open market under current conditions. However, fair market value has the following additional assumptions:

- Both buyer and seller are reasonably knowledgeable about the asset
- Buyer and seller are behaving in their own best interests
- Both parties are free of undue pressure
- Each is given a reasonable period for completing the transaction

Given these conditions, an asset's fair market value should represent an accurate valuation or assessment of its worth in contrast to its current price. These assumptions might make an asset's value higher or lower than its market value. This definition of the term is commonly accepted in accounting, tax law, bankruptcy law, divorces, and the real estate market.

Key Takeaways

The fair market value is the price an asset would sell for on the open market when certain conditions are met.

The conditions are: the parties involved are aware of all the facts, are acting in their own interest, are free of any pressure to buy or sell, and have ample time to make the decision.

Fair market value is different than market value and appraised value.

Tax settings and the real estate market are two areas that commonly use fair market value.

Insurance companies use fair market value in determining certain claim payouts.

Understanding Fair Market Value (FMV)

Fair market value is intentionally distinct from similar terms, such as market value or appraised value, because it considers the economic principles of free and open market activity. In contrast, the term market value refers to the price of an asset in the marketplace.

Therefore, while a home's market value can easily be found on a listing, its fair market value is more difficult to determine.

Similarly, the term "appraised value" refers to an asset's value in the opinion of a single appraiser, thus not immediately qualifying the appraisal as fair market value.

However, in cases where a fair market value is needed, an appraisal will usually suffice.

Due to the thorough considerations used in determining fair market value, it's often used in legal settings. For example, fair market value in real estate is commonly used in divorce settlements and to calculate compensation related to the government's use of eminent domain.

Fair market values are also often utilized in taxation, such as when determining the fair market value of a property for a tax deduction after a casualty loss.

It's essential to assess the fair market value of an item you buy or sell, as it can significantly impact your finances.

Practical Uses of Fair Market Value

Municipal property taxes are often assessed based on the FMV of the owner's property.

Depending on how long the owner has owned the home, the difference between the purchase price and the residence's FMV can be substantial. Professional appraisers use standards, guidelines, and national and local regulations to determine a home's FMV.

FMV is also often used in the insurance industry. For example, when an insurance claim is made due to a car accident, the insurance company covering the damage to the owner's vehicle usually covers damages up to the vehicle's FMV.

Fair Market Value and Taxation

Tax authorities nearly always ensure that transactions are realized at FMV, at least for tax purposes. For example, a father who is retiring may sell the shares of his business to his daughter for $1 so that she can carry on as the owner of the family business.

However, suppose the FMV of the shares is higher. In that case, tax authorities such as the Internal Revenue Service (IRS) may well recharacterize the transaction for tax purposes. The father will need to pay taxes on the disposition of the shares as though he had sold them at FMV to a third party.

Another field of taxation where FMV regularly comes into play is donating property, such as artwork, to charities. In these cases, the donor usually receives a tax credit for the value of the donation. Tax authorities need to ensure that the credit given is for the actual FMV of the object and often ask donors to provide independent valuations for their donations.

Correctly applying fair market value to taxes ensures there won't be adverse monetary implications later on or any claims of fraud by authorities.

How Do You Calculate Fair Market Value?

You can assess rather than calculate fair market value in a few different ways. First, by the price the item cost the seller, via a list of sales for objects similar to the asset being sold, or an expert's opinion. For example, a diamond appraiser would likely be able to identify and calculate a diamond ring based on their experience.

How Do I Know the Fair Market Value of My Home?

Real estate property is assessed by professional appraisers who can tell you its fair market value using standards, guidelines, and national and local regulations to determine it.

How Are Assets Valued in a Divorce?

Each state has its own rules for the division of marital assets. Liquid assets, such as stocks and bonds, are typically valued according to current market prices. Electronics, household items, and vehicles are priced according to their fair market value, which is typically lower than their original purchase price. Real estate, jewelry, artworks, professional degrees, and businesses are harder to value and may require expert appraisal or testimony to determine a fair price.

How Can I Learn the Fair Market Value of My Car?

The Kelley Blue Book is an online guide that can help you determine the fair market value of your car by analyzing data such as trade-in value, private party value, and other areas of research.

The Bottom Line

Fair market value is an assessment of the price an asset could sell for based on several assumptions. This valuation method differs from market value in that market value is the current price for the asset. Market value may be less or more than fair market value (it's believed to be a more accurate reflection of value), which is why fair market value is used by businesses and governments rather than market value.

4. Stated /agreed value:

The value of an insured item as stated by the policyholder, agreed upon by the insurer.

Example: A classic car insured for a stated value of $50,000.

5. Salvage Value:

The estimated resale value of an asset at the end of its useful life.

Example: The salvage value of a totaled car that can be sold for parts.

How Car Insurance Treats a Total Loss

Whether a car is worth repairing will depend on the damage and your state laws

If your car is damaged in an accident and the cost to repair it is more than the car's actual value, it may be considered "totaled." This can be the case if the insurance company decides it can't be repaired safely or if it meets other requirements specified by your state.

Learn how to tell when your car is totaled and what steps to take with your damaged vehicle.

Key Takeaways

Your car may be considered a total loss if the cost to repair it after an accident exceeds the value of the car.

A vehicle may also be considered totaled if it meets certain criteria set by the state.

If another driver was at fault, their property damage liability insurance should cover a totaled car.

If you were at fault in an accident, your collision insurance should cover you if you've purchased that optional coverage.

You may be responsible for the difference between what the insurer pays you and how much you still owe if you have a loan or a lease.

What Is a Total Loss?

For a vehicle to be declared a total loss by an insurance company, it must meet one of several criteria:

The car costs more to repair than its actual cash value. For example, State Farm says it bases actual cash value on the car's "year, make, model, mileage, overall condition, and major options—minus your deductible and applicable state taxes and fees."

The insurer determines that the car cannot be repaired so that it will be safe to drive.

A state's auto insurance laws can dictate when a car is considered totaled.

State insurance laws and insurance companies have formulas for determining whether a car should be considered a total loss. Many states use a "total loss formula"—if the cost of the repairs plus the salvage value of the car exceeds what the car was worth before the accident, then it will be considered a total loss.

Some states set a "total loss threshold"—the damage only needs to exceed a certain percentage of the car's value for it to be considered a total loss. In New York, for example, the threshold is 75%. So, if the cost of repairs plus the car's salvage value exceeds 75% of its actual cash value, then the car is a total loss for insurance purposes.

How to File an Insurance Claim for a Total Loss

If your car was totaled in an accident in which another driver was at fault, you can file a claim with that person's insurance company. Your own insurance company may help you through the claims process. In every state except New Hampshire and Virginia, drivers are required to carry at least a certain minimum amount of property damage liability coverage. (Both New Hampshire and Virginia have a financial responsibility law requiring that drivers without insurance can prove that they could cover any damage they might cause.)

In most states, drivers must have at least $10,000 in property damage liability coverage, and many states set the minimum at $25,000. You can buy more liability coverage than your state's minimum.

On the other hand, if you were at fault (or no other driver was involved), you will file a claim with your own insurance company. To do that, you must have collision or comprehensive insurance as part of your policy.

Collision insurance covers damage to your car in an accident with another vehicle or an object such as a tree or guardrail. Comprehensive covers damage from causes other than a collision, such as fire, wind, flooding, vandalism, or a falling object.

Both comprehensive and collision insurance are optional. They both have deductibles, which is the amount you must pay before your insurer will pay. For example, if you have a $500 deductible and your car is totaled in an accident, your insurer would deduct $500 from your insurance settlement.

Insurance Company's Decision

Whether you or another driver were at fault, the insurance company will assign a claims adjuster to inspect the damage to your car and determine whether it is a total loss.

If you disagree with the adjuster's assessment, you can first try to resolve the matter with your insurance company. If you can't come to an agreement with the insurer, talk to the consumer services personnel at your state insurance department. If that doesn't work, and the amount of money involved is substantial, consider hiring a private attorney or a public adjuster to help press your case.

If you have a car loan or lease and total your car, you may get less money from your insurance company than you owe your lender. However, you'll still be responsible for paying the loan or lease.

A Total Loss on a Financed or Leased Car

If you own your car without an outstanding car loan, you can simply file a claim. When the insurer cuts you a check, you can put the money toward the purchase of another car or use it for other purposes.

If you still owe money on the totaled car, the situation is more complicated, especially if your car is relatively new. Because new cars depreciate quickly in the first few years of ownership, it's not uncommon for the balance on a car loan to be higher than the car's actual value. So, in addition to whatever you receive from the insurance company, you may have to pay for your loan out of pocket. You will also be responsible for the difference if you owe more on your lease than you receive in an insurance settlement.

For both loans and leases, one way to protect yourself is to purchase gap insurance. This insurance is designed to cover the gap between what the insurance company will pay and what you owe.

What are signs that a car is totaled?

A car is often technically totaled when the cost to repair its damage is more than it's worth. Some signs that a car could possibly be totaled are that you cannot drive it, it's leaking significant amount of fluids, or the frame is severely bent.

Will my insurance pay off my car if it's totaled?

Whether your insurance will pay if your car is totaled will depend on several factors. Typically, auto insurance will pay for the value of the car, minus any deductible you owe. The car must be declared officially totaled. Then, once you receive payment, you can shop for a new vehicle.

How does a totaled car affect my credit?

A totaled car will not affect your credit, even if the accident was your fault. Your credit score is based on several factors related to your payment history, including how much debt you have, how long you've had credit, and how reliably you have made payments on time.

Keep in mind that if you don't pay your car loan for any reason, including whether it is related to a totaled car, your credit score will likely take a hit.

The Bottom Line

Determining whether or not to repair a damaged car often depends on whether the car is considered a total loss. If it's a total loss, then your best move in most cases is to file a claim for any coverage provided by your insurance, and then purchase another vehicle.

H. Proximate Cause

Definition: Proximate cause refers to the primary cause of an injury or damage. It is the event that sets off a chain of events leading to the loss, without which the loss would not have occurred.

Example: If a driver runs a red light and hits another car, causing injuries, the driver's action is the proximate cause of the injuries.

What Is Proximate Cause?

There are certain key things you need to prove to show a defendant should be held accountable for a personal injury. You must show that:

- A defendant had a legal duty or obligation, such as the duty drivers have to be safe on the roads
- The defendant failed to fulfill his legal duty
- The defendant's failure was the cause of the injury
- The injuries caused damage the victim can be compensated for

There are two types of causation to look at. You must consider both of the following:

- The actual cause of the accident
- The proximate cause of the accident

In some situations, this is very straightforward because the same action is both the proximate and actual cause. But, in other situations, they are different. This can affect your right to recover compensation.

What Is Actual Cause?

Actual cause is also called cause in fact. It is the event that was the immediate and direct cause of an accident.

For example, if you are walking across the street while a driver is stopped at a red light and the driver's car suddenly enters the intersection and strikes you, the movement of this vehicle is the actual cause of the accident.

If the driver's car hadn't moved into the intersection while you were walking, you would not have been hit.

What Is Proximate Cause?

The proximate cause may be different from the actual cause or the same. Proximate cause is also called legal cause. It refers to a primary cause or an incident that set everything in motion.

If a car that is stopped at a red light enters into an intersection while you're walking across it and strikes you, the car's movement is the actual cause or cause in fact of the pedestrian crash.

But, if the car that struck you was rear-ended by a large truck that pulled up behind it and the truck caused the car to move involuntarily into the intersection, the truck was actually the underlying cause of the incident. Its failure to stop would be the proximate cause of the pedestrian accident.

In this case, the actual cause and the proximate (or legal) cause would be different.

Proving Causation

To recover compensation in a personal injury claim, you must prove a defendant's actions or inaction caused your harm. Courts use several different tests to establish sufficient cause to hold a defendant legally liable for a plaintiff's injuries.

"But For" Test

The "but for" test asks whether the incident that caused a plaintiff's injury would have happened if the defendant was not negligent. A plaintiff can only hold a defendant liable if the event causing their injury wouldn't have occurred "but for" the defendant's negligent acts or omissions.

Under this test, if the event that caused the injury would have occurred anyway, the defendant can't be found legally at fault. This last part is one reason this test is problematic. For example, imagine a driver is rear-ended lightly by another vehicle. They suffer severe injuries from a defective airbag as it deploys. The "but for" test could absolve the manufacturer of liability since the other (negligent) driver caused the incident.

The "but for" test can also be overinclusive. A person who was hit by a careless driver probably would not succeed in a claim against the car dealership, even if the accident wouldn't have happened "but for" its sale of the car.

"Substantial Factor" Test

As the name suggests, the substantial factor test looks at whether or not the defendant's actions or inactions played a significant role in causing an injury to occur. They do not have to be the sole cause of the injury, but they must play more than an incidental role.

For example, say that a driver was speeding and weaving in and out of traffic. The driver was running late to an important meeting because their phone alarm malfunctioned. If the driver swerved into your lane and hit you, his negligent driving was obviously a substantial factor in causing the accident. This would help you establish causation in a personal injury lawsuit against the driver.

However, you would probably not succeed in a product liability claim. Even though the alarm's failure to go off set in motion the chain of events leading to the crash, it had no part in actually causing the crash. On the other hand, if the driver swerved because he was startled by his phone's loud, malfunctioning alarm, this evidence could support a claim against the manufacturer.

Tests For Proximate Cause

Courts across the country take many different approaches to proving causation in civil cases. Most jurisdictions combine elements of the "but for" and "substantial factor" tests. The jury determines whether a plaintiff has established evidence sufficient to meet the applicable standard, which is generally explained in the written jury instructions.

Foreseeability

Foreseeability refers to whether a defendant could have reasonably foreseen or anticipated the consequences of their actions. If the consequences were not foreseeable, the defendant couldn't be held liable for the resulting harm. Many jurisdictions rely heavily on whether the alleged damages were a foreseeable result of the defendant's conduct.

For example, if a driver is speeding, it is foreseeable that he might hit another car and cause property damage and personal injuries. But what if he crashes into a building that is rigged with explosives?

He may not be liable for all of the resulting damage because it is not reasonably foreseeable to expect speeding would cause a massive building explosion.

Determining where to draw the line on what is “foreseeable” is a question for the judge or jury at trial. The amount of guidance the law provides varies from state to state. For example, Illinois case law recognizes that “it is always foreseeable that someone may attempt to rescue a person who has been placed in a dangerous position.”

Because of this doctrine, the party responsible for creating the initial danger can often be held liable for injuries sustained by the rescuer.

It’s worth noting that a defendant can be found liable for an unforeseeable scale of harm if it was a foreseeable type of harm. For example, say a plaintiff experiences severe, life-threatening complications after a minor fender-bender because they have a pre-existing medical condition. The defendant will be liable because personal injuries are a type of damage that is foreseeable in auto accidents.

Direct Causation

Direct causation describes a simple, uninterrupted relationship between an act and the damage that results. Sometimes, there are “intervening causes,” or separate acts that occur in time between the original action and the harm.

Sometimes, an intervening cause completely supersedes the original actor’s liability. For example, say a contractor improperly installed a gas stove, creating a fire hazard. Before any harm occurred, however, the house was hit by lightning and destroyed by fire. This intervening cause would likely destroy any liability by the contractor.

In other cases, intervening causes break the direct causal chain but doesn’t destroy legal liability. For example, a high-speed accident may directly cause the passengers in a car to suffer cuts, bruises and broken bones. It could also cause them to be thrown into the path of oncoming traffic and harmed by another vehicle. The intervening causes wouldn’t prevent the passenger from pursuing claims against the person who caused the original crash.

A court can allocate responsibility for a plaintiff’s damages between multiple parties. Sometimes, a decision includes the percentage share of the harm that each defendant is responsible for. Many jurisdictions also allow “joint and several liability,” which allows a plaintiff to collect their entire damages from any one of the responsible parties.

Harm Within the Risk

Numerous historic court decisions focused on how to limit a defendant’s civil liability. In one famous case, Palsgraf v. Long Island Railroad Company, a woman suffered injuries at a railway station.

While assisting a man boarding a train, two railroad employees caused a package of fireworks to fall on the tracks. The subsequent explosion dislodged some equipment on another platform, which fell and injured the woman.

The court held that the woman couldn’t recover damages from the railroad company, although the employees’ actions had begun the causal sequence that led to her harm. It reasoned that even if the employees’ actions were negligent towards the man, the woman was not a foreseeable victim of harm related to that negligence.

Modern courts have generally abandoned the idea that only foreseeable plaintiffs can recover damages from a legally responsible defendant.

However, insurance companies continue to make coverage decisions using a version of this test, limiting covered harm to the risks associated with ordinary use. If you attach a parachute to your car and drive it off a cliff, your insurer will likely deny your claim, even if you carry a full-coverage policy.

Examples of Proximate Cause

Proximate cause is usually not an issue in cases where the cause of an accident or wrongdoing is clear. In other cases, defendants try to evade liability by disputing the link between their actions and the resulting harm. Questions of whether a defendant's negligence or wrongdoing should lead to legal liability for a plaintiff's injuries apply in all types of cases.

Car Accidents

Many car accidents happen as a result of multiple contributing factors, including drivers who are negligent, drunk or distracted, severe weather and hazardous road conditions. Determining the party (or parties) responsible for a plaintiff's damages often comes down to establishing proximate cause.

Analyzing Proximate Cause in the Context of Car Accidents

In the context of car accidents, proximate cause often hinges on what is foreseeable. Car manufacturers can be held liable for malfunctions and failures that they should have known could lead to accidents.

Drivers can be held accountable for damage to property and personal injuries resulting from their negligence. Employers can be on the hook for accidents caused by their delivery drivers. Requiring proximate cause can place some limits on liability.

Real-Life Examples and Legal Implications

For example, when the weather is inclement, it is highly foreseeable that driving at normal speeds could lead to a collision. A jury may determine that a defendant's failure to slow down was the cause of an accident. This would ordinarily establish proximate cause for the plaintiff to recover compensation for their injuries and property damage.

What if further evidence showed that the plaintiff was improperly transporting a load of fireworks, which exploded and caused most of their injuries? It would be unlikely for a jury to determine that these injuries were foreseeable enough to hold the defendant liable for the full scope of the damages.

Product Liability

In product liability cases, a plaintiff must prove that their injuries were caused by a particular product to recover from its manufacturer. Questions related to causation are very common, especially when products have been on the market for many years. In addition to proving the product was defective or dangerous, the plaintiff must prove it caused their injuries.

Examining Proximate Cause in Product Liability Cases

Proving a product caused injury can be especially difficult in cases where a plaintiff's injuries or damages take years or decades to develop. Even if a plaintiff proves a product was dangerous or defective, it can be difficult to discount the impact of other intervening causes. Proving proximate cause is especially challenging where the actual cause of an injury or illness (such as cancer) is unknown or undeterminable.

Notable Cases Demonstrating Proximate Cause in Product-Related Incidents

Proving the link between a dangerous product and a plaintiff's damages is essential to recovering compensation.

In toxic tort claims, plaintiffs must establish proximate cause between their exposure to a dangerous product and an illness that develops decades later. It is often necessary to present numerous expert witnesses and researchers to establish a pattern of similar injuries in people with known exposure.

Because of the cost and difficulty of overcoming this challenge, cases against the manufacturers are often brought by multiple plaintiffs as class- action lawsuits or consolidated into multi-district litigation. Examples of current, ongoing product liability lawsuits include those involving the Mirena IUD (a medical device that caused serious complications), mesothelioma (cancer caused by exposure to asbestos) and RoundUp (toxic exposure to weedkiller).

Personal Injury Cases

Proving proximate cause is essential in personal injury cases. Although a defendant may have breached their duty of care or committed a legal wrongdoing, a plaintiff can only recover if the defendant's actions or omissions were the proximate cause of their injury.

Application of Proximate Cause in Personal Injury Lawsuits

It can be challenging to establish proximate cause in some personal injury cases, especially if there was more than one contributing cause. The relationship between the defendant's actions or omissions and the foreseeability of the harm must be close enough that it would be fair to hold the defendant liable for the victim's losses. An intervening cause can also affect liability.

Examples Illustrating Proximate Cause in Personal Injury Scenarios

To establish proximate cause in a personal injury case, the plaintiff must prove a defendant's actions or inactions were a substantial factor in causing the event that led to their injuries. A business owner's failure to fix a large parking lot pothole or erect signs indicating the danger may be the proximate cause of a pedestrian's trip-and-fall injuries.

Common Misconceptions Around Proximate Cause

Proximate cause is a legal theory that establishes not only fault but also legal liability. There may be no proximate cause or multiple contributing proximate causes in a case.

A deer that runs in front of a car, prompting the driver to swerve into another vehicle, may be the actual cause of a collision, but no proximate cause would exist. In a multi-car accident, fault and wrongdoing may be assigned to more than one party.

Who Should You Sue When There Were Multiple Accident Causes?

It can be complicated to determine who to hold responsible for harming you if there were multiple causes of an accident or if the actual and proximate cause were different.

The reality, however, is that you may have multiple parties against whom you can pursue a claim for compensation from when you are harmed. For example, if you were struck by a car that entered an intersection you were crossing, you could sue the driver of that vehicle. If it becomes apparent that a truck driver rear-ended that car and was the proximate cause of the incident, that driver could also be brought into the case as well.

I. Deductible

Definition: A deductible is the amount the insured must pay out of pocket before the insurance company pays for a covered loss.

Example: If you have a $500 deductible on your auto insurance and you have an accident causing $2,000 in damage, you pay $500, and the insurance covers the remaining $1,500.

J. Indemnity

Definition: Indemnity insurance compensates the insured for losses or damages up to a certain limit, usually the amount of the loss itself.

Example: Professional liability insurance for a doctor covers legal costs and damages if the doctor is sued for malpractice.

K. Limits of Liability

Definition: Limits of liability are the maximum amounts an insurance company will pay for a covered loss.

Example: A liability policy might have a limit of $1 million per occurrence and $3 million aggregate, meaning it will pay up to $1 million for any single claim and up to $3 million for all claims during the policy period.

What Does Limit of Liability Mean?

A limit of liability is the most an insurance company would pay a policy holder who loses a lawsuit. The policy terms explain exactly how much. In case the policy holder is sued and owes more than the limit of liability provided in the coverage, they would need to pay the rest for the damages out-of-pocket.

An insurance policy stipulates exactly how much it covers for various problems, including liability. Extra liability coverage would require paying more. Insurance companies also set a limit on how much liability coverage they provide. For example, a car insurance company might only allow up to $500,000 of liability coverage. Coverage beyond this limit would require a separate liability insurance policy, which is also known as an umbrella policy.

L. Coinsurance/Insurance to Value

Definition: Coinsurance is a percentage of the cost of a covered loss that the insured must pay after the deductible is met. Insurance to value requires the insured to carry coverage equal to a specified percentage of the property's value.

Example: If a building is insured for 80% of its value and suffers a $100,000 loss, the insured must cover 20% of the loss, or $20,000.

Some business insurance policies include a coinsurance clause. If your policy includes a coinsurance clause, the amount of insurance you have purchased (the limit of insurance) must equal or exceed a specified percentage of the value of the insured property.

For example, if 80% coinsurance applies to your building, the limit of insurance must be at least 80% of the building's value. If the policy limit you have selected does not meet the specified percentage, your claim payment will be reduced in proportion to the deficiency. The coinsurance percentage typically is found on the declarations page.

Here is what you can expect from your claim professional if your policy includes a coinsurance clause. He or she will:

- Determine the applicable limit of insurance
- Determine the value of the lost or damaged property (e.g., your building) at the time of the loss
- Apply the coinsurance percentage to the value of the property
- Determine whether the limit of insurance equals or exceeds that amount
- Explain to you how an unmet coinsurance requirement will affect your claim payment

This is the formula for determining whether the amount of insurance you have purchased (the limit of insurance) meets your coinsurance requirement:

- Value of the property x Coinsurance percentage = Minimum insurance amount required

Here are two examples of how coinsurance works based on a replacement cost value basis.

Scenario 1: Coinsurance requirement is satisfied:

- The property limit is $90,000
- The value of the building at the time of the loss is $100,000 The coinsurance percentage is 90%
- The limit of insurance should be at least $100,000 x 90% = $90,000
- Because the building limit meets the minimum amount of insurance required under the coinsurance clause, the amount due on a claim is not affected:
- The cost to repair the covered damage is $20,000
- The deductible is $500
- The amount payable based on Replacement Cost Value (RCV) is $19,500
- This amount represents 100% of the cost to repair the covered damage minus the deductible.

Scenario 2: Coinsurance requirement is not satisfied:

- The property limit is only $45,000
- The value of the building at the time of loss is $100,000 The coinsurance percentage is 90%
- The limit of insurance should be at least $100,000 x 90% = $90,000
- Because the amount of insurance purchased is only 50% of the amount required ($45,000/$90,000), coverage is afforded for only 50% of the repair cost:
- The cost to repair the covered damage is $20,000

- 50% of the repair cost is 20,000 x .50 = $10,000
- The deductible is $500
- The amount payable based on RCV is $9,500.

M. Occurrence

Definition: An occurrence policy covers claims for injuries or damages that happen during the policy period, regardless of when the claim is filed.

Example: If a person is exposed to hazardous chemicals during the policy period and develops an illness years later, the occurrence policy will cover the claim.

What Is an Occurrence Policy?

An occurrence policy covers claims made for injuries sustained during the life of an insurance policy. Under these types of contracts, the insured party has the right to request compensation for damages that occurred within the timespan that the policy was active, even if several years have since passed and the insurance agreement is no longer in force.

Key Takeaways

An occurrence policy covers claims made for injuries sustained during the life of an insurance policy, even if they're filed after the policy is canceled.

They cater specifically to events that may cause injury of damage years after they occur, such as exposure to hazardous chemicals.

An occurrence policy is an alternative to claims-made ones, which provide benefits only if a claim is filed while the policy is active.

Insurers typically place a cap on the total coverage offered through occurrence policies.

Understanding Occurrence Policies

Liability insurance policies generally fall into one of two categories: Claims- made or occurrence. The latter offers protection against financial loss on incidents that happened while the policy was in effect, regardless of when they're flagged and became apparent. In other words, it's possible to file a claim later, long after the contract has expired, provided there's evidence that its cause or triggering event took place during the period the insurance was active.

Occurrence policies cater specifically to events that may cause injury of damage years after they occur. For example, if an individual is exposed to hazardous chemicals, a significant amount of time could pass before they fall ill.

Occurrence coverage will usually cover the employer and the former employee for life. Years can pass before the injuries or damages become evident, and the policyholder is still protected, even after stopping insurance or switching to another provider.

In insurance, an occurrence is defined as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.”

Insurers typically place a cap on the total coverage offered through such a policy. One form of cap limits the amount of coverage offered each year but lets the coverage limit reset each year. For instance, a company that purchases five years of occurrence coverage with an annual cap of $1 million will allow the policyholder to have up to $5 million in total coverage.

Occurrence Policies vs. Claims-Made

Claims-made insurance only pays out if a claim is filed while the policy is active. That means if you cancel protection and then ask for compensation, you won't be given it—unless an extended reporting period (ERP) or "tail coverage" is purchased.

Business insurance policies are often offered as either a claims-made policy or an occurrence policy. While the claims-made policy provides coverage for claims when the event is reported, the occurrence policy provides coverage when the event occurs.

Claims-made policies are used to cover the risks associated with business operations, such as the potential for mistakes associated with errors and omissions in financial statements. They are also applied to cover businesses from claims made by employees, including wrongful termination, sexual harassment, and discrimination allegations. This type of liability is referred to as employment practices liability (EPLI), and might also cover the actions of directors and officers of the business.

Until the mid-1960s the claims-made wording didn't exist, and into the early to mid-1970s its use was sporadic. The occurrence form now dominates, except for most professional and executive liability exposures, where claims-made policies rule.

Advantages and Disadvantages of an Occurrence Policy

The most obvious benefit of an occurrence policy is that it offers long-term protection. As long as coverage is in place when the incident occurred, it's possible to make a claim on that period years into the future.

Another advantage is that occurrence policy costs tend to be fixed. Premiums generally don't increase unless the risk profile of the insured changes.

On the downside, occurrence policies are, understandably, more expensive than claims-made ones. Occasionally, they can be harder to come by, too.

There's also the risk that a company taking out such a policy underestimates the level of damages it could incur later on down the line, forcing it, as a result, to pay out a chunk from its own pocket.

N. Cancellation

Definition: Cancellation refers to the termination of an insurance policy before its expiration date.

Example: If an insured stops paying premiums, the insurance company may cancel the policy.

What Does Cancellation Mean?

Cancellation, in the context of insurance, is the termination of the insurance policy either by the insurer or the insured before the end of the period of coverage. A policyholder has a right to cancel their policy, although they are subject to limitations presented by the laws of his state. An insurer, however, may cancel a policy based on valid grounds, such as non- payment of insurance premiums, misrepresentation, or concealment.

There are three common cancellation methods of cancellation: pro-rata, short-rate, and flat rate.

Pro-rata cancellation refers to policy termination earlier than its maturity, either at the request of the insured or at the behest of the insurer. In this case, a return premium factor is computed based on the remaining days of coverage less the total number of days in coverage period and multiplied by the premium.

Short-rate cancellation occurs when the insured requests the termination of the policy. In this case, the unearned premium is returned, less a 10% penalty.

Finally, **flat cancellation** takes place when termination occurs on or before the policy start date. In such cases, no penalty or premium is charged.

If an insurance policy contains a cancellation clause, either party may legally cancel the insurance policy before the end of the period after sending a written notice to the other. Depending on the grounds of cancellation, the insured may or may not receive return premiums. If cancellation is based on intentional misrepresentation or concealment, the insured may not be able to receive premium refund.

O. Nonrenewal

Definition: Nonrenewal occurs when an insurance company decides not to renew a policy at the end of its term.

Example: An insurer may choose not to renew a homeowner's policy if the insured has filed multiple claims.

Your car insurance company may drop you as a customer through either policy non-renewal or cancellation. The timing and reasons for the decision affect whether an insurer do a non-renewal or cancel a policy.

Car Insurance Non-Renewal vs. Cancellation

Here's how to distinguish between cancellation and non-renewal of car insurance:

Cancellation can happen during the term of the policy or when the policy term is ending. Car insurance companies typically can't cancel a policy that's been in force for 60 days or more except for specific reasons such as: You commit insurance fraud, you don't make payments, you get convicted of a DUI or your driver's license is suspended or revoked.

Insurers may cancel a policy for those reasons or may instead decide not to renew your policy at the end of the policy's term.

Nonrenewal happens when your insurance company discontinues your policy at the end of the coverage period. A non-renewal can happen through no fault of your own. For example, perhaps the insurer has decided to reduce its number of customers in your area. Car insurance companies have more leeway to issue a non-renewal notice.

What Is Car Insurance Non-Renewal?

Non-renewal is when a car insurance company decides not to renew your policy. This happens at the end of your policy's term.

There are multiple reasons why an insurer may issue a non-renewal, but that decision should not affect whether you can find another policy and doesn't directly affect car insurance rates.

Here's what to know about car insurance non-renewal.

It can happen at the end of your policy.

States may require the Insurance company to give you a notice of a minimum number of days and explain why you're not being renewed. For instance, New York requires at least a 45- to 60-day notice before the expiration date with reasons for the non-renewal.

Non-renewal may occur if your company stops selling policies in your area or reduces the number of policies.

A company could non-renew your car insurance policy if you commit fraud.

Multiple car insurance claims or accidents on your record can cause non- renewal.

Non-renewal doesn't generally lead to higher car insurance rates when you go to buy a new policy.

Reasons for Non-Renewal of Car Insurance

Non-renewal occurs when the insurance company decides not to continue the coverage when the policy expires. Here are common reasons for non- renewal:

- Your insurance company decides to cease business in your state or sell fewer policies.
- Late car insurance payments.
- False or fraudulent information on your insurance application.
- Multiple moving violations or caused car accidents.

What Is Car Insurance Cancellation?

Car insurance cancellation is more serious than non-renewal and may make finding a new car insurance policy difficult. At the very least, you'll probably pay more for car insurance after a cancellation.

Cancellation can occur any time of the year if you commit fraud, don't pay your car insurance costs, or your license is suspended or revoked.

Insurers can't cancel car insurance policies because of too many accidents or claims but may cancel you if you're convicted of a DUI.

State law may dictate how much time an insurance company must give you for policy cancellation. For instance, New York demands that insurance companies notify you at least 20 days before the cancellation or 15 days if it's canceling coverage because you didn't pay premiums.

An insurance company may refund you part of the premium you paid if your policy is canceled.

A policy cancellation may give you problems when you want to buy a policy from another company. And you will probably pay higher car insurance rates.

Reasons for Car Insurance Cancellation

There are several possible reasons for an auto insurance policy to be canceled. The most common reasons are late payments and failure to disclose information on your car insurance application.

Other possible reasons for a canceled auto insurance policy are:

- Poor driving record, including at-fault accidents or moving violations over a set period of time, such as 36 months.
- Suspended driver's license or registration.
- Providing fraudulent information, such as lying about an auto insurance claim.
- Felony convictions, such as driving under the influence.
- You drive for a rideshare company, such as Uber or Lyft and fail to tell your insurance company.
- You have a medical condition that makes you an unsafe driver. For example, Illinois allows a car insurance company to cancel your car insurance if you're diagnosed with epilepsy and your doctor doesn't offer proof that your epilepsy won't impair your driving.

Notice of Non-Renewal or Canceled Car Insurance

If your policy is non-renewed or is canceled, your auto insurance company will send an advance notice with an explanation.

The time frame depends on state laws and the circumstances, but you typically get a notice 30 to 60 days before the cancellation date. For non- renewal, it's generally 10 to 75 days.

How to Get Car Insurance After a Non-Renewal or Cancellation

- If you receive notification that your policy is going to be canceled or discontinued, you'll want to move quickly to get new coverage in place before the termination date. What's the rush? Your insurance company is required to contact your state's motor vehicle department once a car insurance policy is canceled. And you need car insurance to legally drive in most states.
- If you can't find new insurance coverage, your state might require you to turn in your car's tags and surrender your driving privileges.
- If you drive uninsured and cause an accident, you're responsible for paying the medical and repair bills.
- If you're caught driving uninsured, you also face penalties and fines. Additionally, you generally pay more for car insurance after a lapse in coverage because insurance companies consider coverage gaps to be high-risk behavior.

Determine sufficient coverage

It's smart to buy enough liability car insurance to match the amount of your net worth. Avoid buying only the minimum liability coverage needed to drive legally in your state, as this may not be enough to cover even minor accidents.

P. Vacancy and Unoccupancy

Definition: Vacancy refers to a property being empty and not containing any personal property, while unoccupancy means the property is not currently inhabited but still contains personal property.

Example: A house left empty for an extended period without furniture is considered vacant, while a house where the owner is temporarily away but still furnished is unoccupied.

The Homeowners Insurance Vacancy Clause and Unoccupancy Clause- What You Need to Know

Homeowners Insurance Vacancy Clause

If you are a homeowner and have purchased home insurance to protect your property, you must get familiar with the 'homeowners insurance vacancy and unoccupancy clauses.

To understand more about the homeowner's insurance vacancy and unoccupancy clause, here are some terms you need to know:

Vacancy Clause:

According to Merriam-Webster, a vacancy clause is typically defined as an amendment made to the property insurance coverage that doesn't allow the property to be vacant beyond the period mentioned in the contract.

When included in the homeowner's insurance, the vacancy clause would limit the insurance coverage for your home during the period of vacancy either partially or fully.

If your home stays vacant for a period exceeding 30 or 60 days, as mentioned in the insurance agreement, the property will not be covered by your homeowner's insurance during the vacancy period. The number of days is defined in the policy agreement and is specific to the insurance company insuring the home. It's important to read your policy.

The term 'vacancy' has varied meanings depending on your insurance. Most insurance companies define vacancy as 'no people, no contents' for 30-to-60-day period.

In such case, in the event of any loss or damage to your home, like damaged pipes, theft, or vandalism, while the property lay vacant, the insurer will decide what constitutes vacancy and apply the coverage limitations accordingly.

Unoccupied House Vs. Vacant House

As per the insurance companies, there is a distinct difference between an unoccupied house and a vacant one. The homeowner's intention to return is the primary consideration while distinguishing them.

Unoccupied house:

Where the home is left in a manner that suggests that the owner would return shortly, it is an unoccupied home. In the unoccupied house, the power and utilities are left on. The homeowner's furniture and other belongings remain inside.

Unoccupied homes are provided with less limited coverage than a vacant home. But there are limitations, nonetheless. Of note, some policies covering secondary or vacation homes may have a shorter time frame for unoccupancy. Check your policy to better understand any limitations for properties covered by homeowners' insurance policies.

Vacant house:

Where the property is free from any belongings, it can be considered a vacant home for insurance purposes. Vacant properties face a higher risk of loss as no one is around to look after the homes for an extended period.

Most homeowners' insurance policies restrict coverage when the house is left vacant for a while, usually between 30 to 60 consecutive days, depending on the insurance company's policy form.

For example, suppose you lived your entire life in the Northern United States but, after retirement, chose to live in any state down south and sell your home. You move out with all of your personal belongings and turn off all utilities. Your house would be considered vacant for insurance purposes.

If the pipes burst, causing water damage to your house, you may not claim such damages under your homeowner's insurance as the property was vacant for an extended time, attracting the vacancy clause in your insurance contract. More than likely, your coverage would not be renewed at expiration, and you'd need to buy a vacant home policy.

Significance of the vacancy clause:

If a house is vacant during the time of loss or damage to the property from theft, vandalism, water, fire damage, etc., the insurance company will not cover it.

When the property lies vacant for an extended period, no one is around to protect it from theft or vandalism.

Where there is water damage from broken water pipes, no effort could be made by the house owner to shut off the water to reduce the damage caused to the property.

A vacant property carries a higher risk for the homeowner's insurance policies. Specialty vacancy insurance policies are available at a higher premium to cover houses during the vacancy.

What to do when you attract the vacancy clause?

If your house stays vacant for a period exceeding the time frame stated in your policy, your homeowner's insurance policy will not cover the damages incurred after that time period during the vacancy period.

Tips to mitigate the risk of damage during a vacancy

- If you plan to keep your home vacant for a long time, you can take the following steps to prevent damage to your property during the vacancy period.
- Install video surveillance/cameras on your property to prevent damage from theft or vandalism.
- Decide on the utilities that are necessary to maintain your house and shut down those that are not required while your home is vacant to prevent damage.
- Check your plumbing systems thoroughly before leaving to prevent breaking of pipes and avoiding water damage to your property. Turn off your water.
- Make sure your fire protection systems and HVAC systems are working correctly.

Insurance policies often come with varying conditions, coverages, exclusions, and limits that can overwhelm and confuse you.

Q. Liability

Definition: Liability insurance provides protection against claims resulting from injuries and damage to other people or property.

Example: Auto liability insurance covers damages if you are at fault in a car accident that injures another person.

What Is Liability Insurance Coverage?

Liability insurance helps protect you financially if you're found legally responsible for property damage or personal injury to a third party. This liability protection is part of most home, auto and business insurance packages and customized for different situations.

Personal Liability Insurance

You may want to consider coverage to help protect you in personal situations, including:

Personal liability insurance to help protect you if someone gets hurt while on your property. It can also help cover you if you're responsible for damaging another person's property. This coverage is part of your homeowners or renters' insurance policy.

Bodily injury liability insurance to help pay for medical expenses resulting from a car accident that you caused.

Property damage liability coverage to help pay for repair damages from an accident you caused or that you're found responsible for.

Umbrella insurance, which extends your homeowners and auto liability coverage limits.

How Does Liability Insurance Work?

Depending on the type you have, a liability insurance policy helps protect you from a covered loss. These policies work when:

- A loss occurs during your policy period
- You file a claim with your insurance company
- You have a covered cause of loss

It's a good idea to check each liability insurance policy you have to make sure you understand how it works. Policies may have exclusions (things that are not covered) and list the types of losses they won't cover.

Do I Need Liability Insurance?

Nearly all states require that you have auto insurance, which includes liability insurance. This protects you if you injure another party or cause property damage in an accident. Not all states require you to have personal liability coverage, which protects you if someone is injured on your land or property.

However, mortgage lenders often require liability coverage in a homeowners insurance policy. In addition, some landlords may also require liability insurance in a renters insurance policy. You may consider having liability insurance coverage to help protect you and your assets against unexpected costly claims.

How Much Liability Insurance Do I Need?

When selecting your coverage limits, you should determine what assets you want to protect, such as your home, savings and investments. It is recommended that you select a coverage limit for your policy that matches or exceeds your net worth, so you have enough coverage to protect your assets if someone sues you.

Liability Insurance Minimums and Requirements

Your state may have minimum liability insurance requirements for car insurance policies. State car insurance laws vary, but you'll likely need to have minimum coverage for:

- Bodily injury liability
- Property damage liability

For other types of liability insurance, several factors can impact your coverage needs. These include:

- Your claims history
- Your location

You can work with an insurance agent or specialist to better understand your local laws. This can help you make sure that your coverage complies with state rules.

Liability Insurance Restrictions and Exceptions

Liability insurance helps cover third-party claims of property damage or bodily injury. These policies don't provide coverage for the policyholder. For example:

Bodily injury liability coverage won't help cover your medical bills if you get hurt in a car accident that you caused. You'll need personal injury protection (PIP), also known as no-fault insurance, to protect you in these situations.

Property damage liability insurance won't help pay to repair your car if it's damaged in an at-fault accident. Collision coverage can help you with this kind of claim.

Like most other types of insurance, your liability policies don't cover intentional acts or criminal actions. It's important to review your insurance policy on a regular basis. You'll want to make sure you understand the exclusions and limitations of your policy.

1. Absolute Liability

Definition: Absolute liability is imposed without regard to fault or negligence.

Example: Owners of dangerous animals may be held absolutely liable for injuries caused by their pets.

2. Strict Liability

Definition: Strict liability holds a party responsible for damages or injuries regardless of fault or intent.

Example: Manufacturers can be held strictly liable for defective products that cause harm.

3. Vicarious Liability

Definition: Vicarious liability occurs when one party is held responsible for the actions of another.

Example: Employers can be held vicariously liable for the actions of their employees during work hours.

R. Negligence

Definition: Negligence is the failure to exercise the care that a reasonably prudent person would exercise in similar circumstances.

Example: A driver who runs a red light and causes an accident is negligent.

S. Binder

Definition: A binder is a temporary insurance contract that provides coverage until a permanent policy is issued.

Example: An insurance agent may issue a binder to provide immediate coverage for a new car purchase.

T. Endorsements

Definition: Endorsements are additions or changes to an existing insurance policy.

Example: Adding a rider to a homeowner's policy to cover expensive jewelry is an endorsement.

U. Blanket vs. Specific

Definition: Blanket insurance covers multiple items or locations under a single policy, while specific insurance covers a particular item or location.

Example: Blanket insurance might cover all buildings on a property, while specific insurance covers only one building.

V. Burglary, Robbery, Theft, and Mysterious Disappearance

Definition: These terms refer to different types of property crimes. Burglary involves unlawful entry, robbery involves force or threat, theft is the unlawful taking of property, and mysterious disappearance refers to property that is missing without explanation.

Example: A stolen car is a case of theft, while a break-in at a home is burglary.

W. Warranties

Definition: Warranties are promises made by the insured that certain conditions will be met.

Example: A warranty in a marine insurance policy might require the insured to maintain the vessel in seaworthy condition.

X. Representations

Definition: Representations are statements made by the insured during the application process that are believed to be true.

Example: Stating that you have a home security system when applying for homeowner's insurance is a representation.

Y. Concealment

Definition: Concealment is the intentional withholding of information by the insured that is material to the risk.

Example: Failing to disclose a previous heart condition when applying for life insurance is concealment.

Z. Deposit/Premium Audit

Definition: A premium audit is a review of the insured's records to determine the actual premium due for the coverage provided.

Example: A workers' compensation insurer may conduct an audit to verify payroll amounts and adjust the premium accordingly.

AA. Certificate of Insurance

Definition: A certificate of insurance is a document that provides evidence of insurance coverage.

Example: A contractor may provide a certificate of insurance to a client to show proof of liability coverage.

BB. Damages

Definition: Damages are monetary compensation awarded to a party for loss or injury.

Example: A court may award damages to a plaintiff in a personal injury lawsuit.

Compensatory

Definition: Compensatory damages are intended to compensate the injured party for actual losses.

Example: Medical expenses and lost wages are compensatory damages.

CC. General

Definition: General damages compensate for non-monetary losses such as pain and suffering.

Example: Compensation for emotional distress is a general damage.

DD. Special

Definition: Special damages compensate for specific monetary losses.

Example: Reimbursement for medical bills is a special damage.

EE. Punitive

Definition: Punitive damages are intended to punish the wrongdoer and deter future misconduct.

Example: A court may award punitive damages in a case of gross negligence.

FF. Compliance with Provisions of Fair Credit Reporting Act

Definition: Compliance with the Fair Credit Reporting Act (FCRA) involves adhering to regulations that govern the collection, dissemination, and use of consumer information.

Example: An insurance company must provide notice to an applicant if their credit report is used to deny coverage.

The Fair Credit Reporting Act (FCRA) is a federal law designed to ensure the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. Here's a summary of key compliance provisions:

Accuracy and Fairness: Consumer reporting agencies must ensure the information they collect and distribute is accurate and fair. They are required to correct or delete inaccurate, incomplete, or unverifiable information.

Consumer Rights:

Notification: Consumers must be informed if information in their file has been used against them, such as in credit, insurance, or employment decisions.

Access to Information: Consumers have the right to know what is in their file. They can request and obtain all the information about them in the files of a consumer reporting agency.

Free Reports: Consumers are entitled to a free disclosure of their credit report once every 12 months from each of the nationwide credit bureaus and from nationwide specialty consumer reporting agencies.

Dispute Inaccuracies: Consumers can dispute inaccurate or incomplete information. The agency must investigate unless the dispute is frivolous.

Permissible Purposes: Information in a consumer report can only be provided for specific purposes, such as credit, insurance, employment, or other legitimate business needs.

Identity Theft Protections: The FCRA includes provisions to help protect consumers from identity theft, such as placing fraud alerts on credit reports.

Enforcement: The Federal Trade Commission (FTC) and the Consumer Financial Protection Bureau (CFPB) enforce the FCRA. They ensure compliance and handle violations

These provisions help maintain the integrity of consumer reporting and protect consumer rights.

III. PROPERTY: POLICY PROVISIONS AND CONTRACT LAW

A. Declarations

Definition: The declarations page of an insurance policy provides a summary of the key details of the policy, including the names of the insured and insurer, the coverage limits, the premium amount, and the policy period.

Example: The declarations page of a homeowner's insurance policy lists the insured's name, the address of the insured property, the coverage limits for the dwelling and personal property, and the annual premium.

An insurance declarations page is a summary of your insurance policy in one or two pages. It lets you know what's covered, who's covered and how much you're going to pay for coverage.

Declarations pages are also called "dec pages" for short. There are differences between auto insurance, homeowners' insurance and renters' insurance declarations pages.

Auto insurance declarations page

An auto insurance declarations page is an overview of your car insurance policy, but it doesn't contain all the fine points. Those are laid out in other sections of the policy, which go into much greater detail.

Your car insurance declarations page will contain information about:

- When the policy is valid.
- What vehicles are covered.
- Which drivers are covered.
- What your coverage limits are.
- What your deductibles are.
- How much your premium is.
- What discounts you've received.
- Any optional coverage you have.

These facts are all presented at a summary level. For instance, your coverage limits might list bodily injury liability coverage of $30,000 per person and $60,000 per accident. The declarations page won't say that this coverage doesn't apply when you intentionally attempt to harm someone or that you won't be covered when using your car for business.

Exceptions are laid out in the policy details pages. You'll know you've found the details of your policy when you find page after page of numbered paragraphs, subsections and sections where words like "you" are defined.

The dec page is meant to be a quick overview of your policy. It's also an easy place to start understanding all of the parts of your coverage. You can see at a glance if you have the coverage you need and how much you're currently paying.

Your declarations page also might contain contact details for your agent, information about your premium payment schedule and names of any drivers specifically excluded from the policy.

Whenever you compare car insurance quotes, it makes sense to keep a copy of your declarations page nearby.

Homeowners insurance declarations page

A homeowners insurance declarations page is similar in layout to an auto insurance declarations page. You'll see details about your policy such as who and what's covered. You'll also see your premium and any discounts you've received.

Renters insurance declarations page

The declarations page for renters' insurance looks very much like a homeowners insurance declarations page. The main difference is in the types of coverage you'll see and the lack of any mortgage details.

A renters insurance declarations page will cover:

- When the policy is in force.
- What your personal property limits are.

- What your deductible is.
- How much your premium is.
- Any discounts you're receiving.
- Any additional coverage options.

The main difference between renters and homeowners' insurance is that renters' insurance covers the stuff in your rental, like your clothes, furniture and electronics but not the property you live in. Landlords will have insurance to cover the building in case of fire or another catastrophe.

Renters insurance also covers you for any damage you might cause to the property or to people on the property.

B. Insuring Agreement

Definition: The insuring agreement is the section of an insurance policy that outlines the insurer's promise to pay for covered losses in exchange for the premiums paid by the insured.

Example: In an auto insurance policy, the insuring agreement may state that the insurer will cover damages resulting from collisions, theft, and other specified perils.

C. Conditions

Definition: Conditions are the provisions in an insurance policy that outline the duties and responsibilities of both the insured and the insurer.

Example: A condition in a homeowner's policy may require the insured to report a loss within a certain time frame and to protect the property from further damage. For more information, visit The Balance[3].

D. Exclusions

Definition: Exclusions are specific situations or perils that are not covered by an insurance policy.

Example: A homeowner's insurance policy may exclude coverage for flood damage, meaning any damage caused by flooding would not be covered.

E. Definition of the Insured

Definition: The insured is the person or entity covered by an insurance policy.

Example: In a homeowner's insurance policy, the insured typically includes the policyholder and their family members living in the same household.

The important points

- Insured refers to anyone covered by the policy, whether they're specifically named or not.
- Different insurance companies define "insured" differently.

What is an insured?

In insurance, the insured is the person or business that is covered by an insurance policy. One policy can (and usually does) cover multiple insureds.

Example

Stanley is a homeowner who lives with his two kids, his wife, and her father. Stanley bought the insurance policy that protects their home, and it's his name written on the front of the policy. However, his insurance policy extends coverage to Stanley's partner, his relatives, and his partner's relatives, as long as they're living with him in the house.

In this example, Stanley is the named insured: his name specifically appears on the policy. The terms of his home insurance policy extend coverage to the other people living with him: his kids, his wife, and his father-in-law are all considered insureds under his policy, even though the policy doesn't name them specifically.

Policies of insurance always have a named insured, and sometimes more than one. Plus, insurance policies often extend coverage to people who aren't actually named on the policy.

Home insurance policies typically cover family members of the named insured if they're living in the same household. Commonly, children who are living away from home for school are also insured.

Insurance companies often differ slightly in their definition of insured. You'll be able to find your insurer's definition somewhere in your policy wordings.

The definition of an insured includes the named insured, plus:

- Living in the same household:
- The named insured's partner
- Relatives of the named insured or their partner
- Anyone under 21 years old in the care of the named insured or their partner
- Any domestic employees
- Living outside the household:
- The parents of the named insured or their partner, while they live in a residential care facility
- Any students who are dependent on the named insured or their partner

What is the difference between insured and insurer?

Now that we've defined insured, what's an insurer?

An insurer is the company that is insuring the insured. Or, less confusingly: the insurer is the company that agrees to cover the insured's claims under the policy. If the insured makes a claim, the insurer is the one who pays the claim settlement.

Often, the insurer will be the same company that sold the policy, though not always.

If you bought your insurance policy through a broker, that broker is not your insurer. The insurer is the company that underwrites the policy and pays any claims. Your insurer is clearly identified on your policy's declarations page.

F. Duties of the Insured

Definition: These are the responsibilities that the insured must fulfill after experiencing a loss to ensure coverage under the policy.

Example: After a fire, the insured must promptly notify the insurer, protect the property from further damage, and provide a detailed inventory of damaged items.

What Does Duties of The Insured Mean?

Duties of the insured refer to the responsibilities of the policyholder, which generally requires the exercise of good faith and maintenance of fair dealing. These duties are often listed in the conditions section of the insurance contract.

Some of the duties of the insured include the following:

- Disclose material information,
- Avoid concealment and misrepresentation,
- Report loss or damage to the authorities,
- Provide notice of claim to the insurer,
- Prepare an inventory of the damaged or stolen property, and
- Provide proof of loss to the insurer.

The inability of the insured to comply with their duties is a ground for breach of contract, cancellation of the policy, and forfeiture of the premiums paid.

G. Obligations of the Insurance Company

Definition: These are the duties that the insurer must fulfill as part of the insurance contract, including investigating claims and paying covered losses.

Example: The insurer must investigate a claim promptly and pay the claim if it is covered under the policy terms.

The Responsibilities of an Insurance Company

In addition to the duties outlined in your policy, insurance companies have responsibilities under both common law and statutory law. In general, the insurance company owes you a duty of good faith and fair dealing when handling any transaction. It also has the obligation to faithfully investigate and honor valid insurance claims.

Fair Deal

An insurance company's duty of good faith and fair dealing means it must always act in the client's best interest. This responsibility, implied in all insurance agreements, prevents the company from acting in bad faith in transactions involving your claim. If it breaches this responsibility you are entitled to sue for damages.

General Duties

An insurance company has a legal duty to fully investigate your claim, not just the parts that support their position. It must also provide you with all necessary information so you can protect your claim under the policy.

Additionally, the company must respond to your communications and promptly pay your claim if it's found valid.

Insurance Contract

Your insurer must honor any responsibilities outlined in your policy. It's free to provide you with rights above and beyond those provided by law, so your agreement may have extra responsibilities. Additionally, if a provision in your policy is found to be ambiguous it's interpreted by a court as being in your favor if there's a dispute.

Duty to Defend

Depending on the nature of your agreement, your insurer may have a duty to indemnify or defend you under certain circumstances. The duty to defend provides you with legal representation if you're sued. The duty to indemnify pays for any legal judgments against you. Both are dictated by the terms of your policy.

H. Mortgagee Rights

Definition: Mortgagee rights are the protections provided to a mortgage lender under a property insurance policy.

Example: If a home with a mortgage is damaged, the insurance company will pay the mortgage lender for the loss before the homeowner.

Mortgagee Clause: What it Means, How it Works, Example

A mortgagee clause is found in many property insurance policies, and it provides protection for a mortgage lender if a property is damaged.

Normally, you will be asked to agree to a mortgagee clause when you take out a mortgage.

In effect, a mortgagee clause is a separate agreement between your mortgage lender (the mortgagee) and the insurance company that is insuring your property. A mortgagee clause ensures that if your property is damaged while you are paying off the mortgage, the insurance company will pay your mortgage lender for this loss, even though it’s covered on your insurance policy.

A lender would not lend a substantial amount of money secured by property without the inclusion of a mortgagee clause in the borrower’s property insurance policy, so they are an important part of your mortgage and property insurance contracts.

Key Takeaways

A mortgagee clause is a part of your homeowners insurance policy that protects your lender—the mortgagee—from losses incurred due to damage to your property.

Many mortgage providers require a mortgagee clause in place to grant a mortgage.

A mortgagee clause states that if a property is damaged during the mortgage period, the insurance company must pay the mortgagee for this.

For example, if you obtain a mortgage to buy a home or property and that property is then destroyed in a fire, the mortgagee clause would ensure that the loss would be payable to your lender even though it’s part of your insurance policy.

What Is a Mortgagee Clause?

Most mortgage providers (mortgagees) will require you (the borrower, or mortgagor) to take out homeowners' insurance to get a loan. Homeowners insurance provides you with protection against damage to your property and its contents, but it also provides protection for your lender. The mortgagee clause is a key part of these protections.

A mortgagee clause states that if a property is damaged during the mortgage period, the insurance company must pay the mortgagee for this. For example, if you obtain a mortgage to buy a home or property and that property is then destroyed in a hurricane, the mortgagee clause would ensure that the loss would be payable to your lender even though it's part of your standard insurance or hurricane insurance policy.

This clause also protects the lender if you cause damage to the property, which leads the insurance provider to cancel the policy. Fire damage is one of the most common causes of home damage and is usually protected by insurance. But not when the damage is caused intentionally. If you commit arson—an act that would void your insurance policy—the clause protects the mortgagee, ensuring that your lender will still be covered.

Who's Who

It's important to understand the terminology used in mortgage negotiations. A mortgagor is a borrower. A mortgagee is a lender that provides a mortgage loan to a mortgagor.

How a Mortgagee Clause Works

Most lenders require that borrowers have homeowners' insurance and that the insurance policy include a mortgagee clause. The policy will state who has the lien within the policy. In some cases, if it's not a requirement to get a mortgagee clause, then a borrower must contact a lender to add the clause to their current contract.

Mortgagee clauses provide valuable protection for lenders because of the way that mortgages work. When you take out a mortgage, you are essentially offering your home as collateral for a loan, which you promise to pay back. If you can't keep that promise, then your lender (the mortgagee) can foreclose on the property and sell it to recoup costs. But if the property is damaged, then the mortgagee's investment is put in jeopardy. The mortgagee clause ensures that the mortgagee will be paid out even if you are responsible for the damage to the property.

In other words, a mortgagee clause is a form of indemnity protection for the lender, because if there is any loss or damage to the collateral property, the lender is indemnified up to the interest that it has in that property.

Mortgagee clauses are an important component of the mortgage market. Without the protection of the mortgagee clause, financial institutions would be unlikely to loan the large amounts of money necessary to purchase homes, office buildings, or factories.

What Is an Example of a Mortgagee Clause?

Mortgagee clauses protect your lender from damage to your property, even if you caused it. So, if you commit an intentional criminal act that voids your insurance policy, the clause protects the mortgagee, ensuring that your lender will still be covered.

Is the Mortgagee the Borrower?

No. A mortgagee is a lender—specifically, an entity that lends money to a borrower for the purpose of purchasing real estate. In a mortgage transaction, the lender serves as the mortgagee and the borrower is known as the mortgagor.

Can a Person Be a Mortgagee?

Yes. Anyone who lends you money to buy a home and enters into a mortgage contract with you can be a mortgagee. When you sign a mortgage contract with an individual, it's called a private mortgage.

The Bottom Line

A mortgagee clause is a part of your homeowners insurance policy that protects your lender (the mortgagee) from losses incurred due to damage to your property. Many mortgage providers will require a mortgagee clause to grant you a mortgage.

A mortgagee clause states that if a property is damaged during the mortgage period, the insurance company must pay the mortgagee for this.

I. Proof of Loss

Definition: A proof of loss is a formal statement made by the insured to the insurer regarding a claim, detailing the extent of the loss and the amount being claimed.

Example: After a burglary, the insured submits a proof of loss form listing the stolen items and their values.

What is proof of loss?

A proof of loss is a formal document you must file with an insurance company that initiates the claim process after a property loss. It provides the insurer with specific information about an incident – its cause, resulting damage, and financial impact. Once the insurer has received the proof of loss, it can send you a check for repairing or replacing your damaged item if it is covered with your policy.

Is proof of loss required for all types of insurance?

Insureds must file a proof of loss form to receive benefits under a commercial property insurance policy. All forms of insurance have a similar process for notifying insurers when a loss occurs. This includes:

- General liability insurance
- Business owner's policy
- Workers' compensation insurance
- Commercial auto insurance
- Business interruption insurance
- And many other types of small business insurance.

What should a proof of loss form include?

Each carrier has a specific form or a preferred format for submitting a proof of loss. Generally, you must provide your insurer with a complete description of the loss, including:

- Date and time
- Incident precipitating the loss (storm, flood, theft, etc.)
- Property involved in the loss
- Nature and scope of damage incurred
- Evidence of the loss (photos, police report, purchase receipts)
- Current property replacement value
- The party (or parties) with a financial interest in the property

The insurer will then process the form and determine how much it will offer the insured as a claim settlement.

When should you file your proof of loss with your insurer?

Under the proof of loss policy provision, you must file your form as soon as possible after the incident, but no later than the date specified in your policy (often 60 days).

Can your insurer refuse to accept your proof of loss form?

Your insurer can refuse to process your proof of loss form in the following cases:

- You didn't answer all the questions.
- You failed to include supporting documentation.
- You didn't sign the form.
- You didn't have your signature notarized.

In these instances, the company might return the form to you for revisions. However, it can't reject your form just because it doesn't like the amount of benefits you're requesting.

What happens after you file your proof of loss?

Your insurance proof of loss form kicks off a formal claims process. It typically includes the following steps:

- Your insurer reviews your proof of loss and attached documentation.
- The insurance company determines whether your policy covers the claimed items. For example, if your policy covers named perils only and the loss isn't named, there will be no coverage.
- A financial value is assigned to each item, either based on a replacement cost or actual cash value.
- The carrier totals the value of all items and offers to settle the claim for the bottom-line amount.
- You will have a chance to review your insurer's offer and decide whether or not to accept it.

- If you don't accept it, you can negotiate with the insurer for a larger settlement.
- If you accept its settlement offer, the insurance company will now apply your deductible (your share of the loss) to that amount.

J. Notice of Claim

Definition: A notice of claim is a formal notification to the insurer that a loss has occurred, and a claim is being made.

Example: After a car accident, the insured sends a notice of claim to their auto insurance company to start the claims process.

What is a Notice of Insurance Claim?

Navigating an accident claim can be overwhelming, but understanding the importance of a Notice of Insurance Claim can pave the way to securing your rightful compensation.

Accidents can be distressing, especially when they result from someone else's negligence.

A crucial step in securing the compensation you deserve following an accident is submitting a "Notice of Insurance Claim" to the at-fault party's insurance provider.

A "Notice of Insurance Claim" is a formal written notice that the claimant (you) sends to an insurance company (the "insurer"). It informs the insurer about your intention to file an insurance claim for an injury caused by their policyholder (the "insured").

This document is often the initial step in the process of pursuing a personal injury claim. It helps by properly documenting your claim and establishing a clear communication line with the insurance company.

When is a Notice of Insurance Claim appropriate?

A Notice of Insurance Claim is applicable in almost any case in which someone else was at fault for your injuries. This may include:

- Accidents involving children
- Car accidents
- Truck accidents
- Slip and fall cases
- Boating accidents
- Bicycle accidents
- Motorcycle accidents

When to send a Notice of Insurance Claim

It's important to send a Notice of Insurance Claim to the insurer as soon as possible after suffering your injury. Doing so ensures that the incident is still fresh in your mind and the pertinent details are correct. What's more, insurance companies (and jurors) tend to take allegations more seriously when they are raised without delay.

It's a good idea to send the Notice of Insurance Claim via certified mail with a return receipt requested so you have proof that it was received.

Every state has a statute of limitations that requires plaintiffs to file a lawsuit within a certain period of time, or else the lawsuit will be forever barred. It's important to keep in mind that a Notice of Insurance Claim is NOT a substitute for a lawsuit and, therefore, will not stop the statute of limitations from running.

Key elements of the Notice of Insurance Claim

Your Notice of Insurance Claim should include a few essential details, including:

- Your contact information
- The date of the accident
- A brief description of the accident
- A brief description of the injuries sustained
- It's also important to request a written confirmation of the liability insurance coverage for the insured for the date of the accident and whether the insured contends that anyone other than themselves may be liable.

K. Appraisal

Definition: An appraisal is a professional assessment of the value of property, such as real estate, a business, or personal items, conducted by an authorized appraiser.

Example: A homeowner gets an appraisal to determine the market value of their house before selling it.

What Is an Appraisal?

An appraisal is a valuation of property, such as real estate, a business, collectible, or an antique, by the estimate of an authorized person. The authorized appraiser must have a designation from a regulatory body governing the jurisdiction of the appraiser. Appraisals are typically used for insurance and taxation purposes or to determine a possible selling price for an item or property.

Key Takeaways

An appraisal is an assessment of the fair market value of a property, business, antique, or even a collectible.

Appraisals are used to estimate the value of items that are infrequently traded and are unique.

The authorized appraiser must have a designation from a regulatory body governing the jurisdiction of the appraiser.

Appraisals can be done for many reasons such as tax purposes when valuing charitable donations.

Home appraisals can positively or negatively impact the sale of a house or property.

Appraisals help banks and other lenders avoid losses on a loan.

Appraisal: An assessment of the fair market value of a property by an authorized person.

Understanding Appraisals

Appraisals are used in many types of transactions, including real estate. If a home valuation, for example, comes in below the amount of the purchase price, mortgage lenders are likely to decline to fund the deal. Unless the prospective buyer is willing and able to come up with the difference between the appraised value and the lender's financing offer, the transaction will not go forward.

The appraiser can use any number of valuation methods to determine the appropriate value of an item or property, including comparing the current market value of similar properties or objects.

Appraisals are also done for tax purposes when determining the value of charitable donations for itemized deductions. Deductions can reduce your taxes owed to the IRS by deducting the value of your donation from your taxable income.

Appraisals can also be a helpful tool in resolving conflicts between heirs to an estate by establishing the value of the real estate or personal property to be divided.

Types of Appraisals Home Appraisals

A home valuation is necessary during the process of buying and selling a home, as well as a refinance of an existing mortgage. A refinance is when a loan or mortgage is reevaluated and updated to current interest rates and new terms.

An appraisal determines the home's value to ensure that the price reflects the home's condition, age, location, and features such as the number of bathrooms. Also, valuations help banks and lenders avoid loaning more money to the borrower than the house is worth.

In the event of default, when the borrower can't make the payments anymore, the bank uses the appraisal as a valuation of the home. If the home is in foreclosure, whereby the bank takes possession of the house, it must be resold to help the lender recoup any losses from making the mortgage loan.

It's important to remember that when a bank lends for a mortgage, it gives the full amount of the home's value to the seller on the date it's sold. In other words, the bank is out the money and, in return, has a promise to pay, plus interest, from the borrower. As a result, the valuation is important to the lending process since it helps the bank avoid losses and protect itself against lending more than it might be able to recover if the borrower defaults.

Note

A home appraisal is separate from a home inspection, which is completed to determine the condition of the home and identify any potentially serious issues before a buyer moves forward with closing.

Collectibles or Antiques

Professional appraisals can be done for many items, including collectibles, antiques, or grandma's silver. Ideally, you'll want multiple valuations for an item from an accredited professional. Appraisers might charge an hourly rate or a flat fee.

A certified appraiser's valuation will likely be fair and unbiased, whereas the local collectible shop has an incentive to offer you less for the item. Also, owners can get an idea of an item's value by checking collectible magazines and online appraisal websites. Most websites charge a small fee, such as $10, to value an item. Of course, obtaining a value online is done through photos of the item and is not an official valuation, but it should give you an idea of what it's worth before proceeding. If you decide to pursue an appraisal, the American Society of Appraisers has thousands of members and is a great place to begin searching for an accredited professional.

Appraisals and Insurance

Some types of insurance policies also require appraisals of goods being insured. Homeowners' and renters' insurance policies protect policyholders against the loss of personal property due to theft or damage. These blanket policies cover items up to a preset dollar limit. Obtaining an appraisal of the contents of a home creates an inventory of the owner's property and establishes its value, which helps to ensure a swift settlement if a claim is filed.

When the value of specific items exceeds a homeowners policy limit, the policyholder may wish to obtain additional insurance that covers luxury items such as jewelry or collectibles, including art objects and antiques. Before issuing personal property insurance policies for high-end items, many insurance underwriters require applicants to have the object appraised. The appraisal creates a record of the item's existence, along with its description. It also helps establish the item's actual value.

Some insurance contracts include an appraisal clause that specifies the owner agrees to obtain an appraisal from a mutually agreeable expert in the event of a dispute between the owner and the insurance company.

Neutral appraisals can speed the resolution of a settlement and keep disputes from escalating into lengthy and expensive lawsuits.

The actual amount you pay for a home appraisal can depend on where the property is located and how much time is required to complete the appraisal.

Home Appraisal Process and Cost

The home appraisal process typically begins after a buyer makes an offer on a home and that offer is accepted by the seller. The buyer's mortgage lender or broker may order the appraisal on their behalf, though the buyer is typically expected to pay for it out of pocket. On average, a home appraisal for a single-family property runs between $300 and $450 while appraisals for multi-family homes can start at around $500.

Once the appraisal is ordered, the appraiser will schedule a time to visit the property. The appraiser will then conduct a thorough review of the interior and exterior of the home to determine what it's worth. This may require them to take measurements or photos of the property.

Appraisals can take a few minutes to a few hours to complete, depending on the details of the home and the appraiser's methods.

After visiting the home, the appraiser will use the information they've collected to create a reasonable estimate for the home's value. At this stage, the appraiser will also look at the values of comparable homes in the area. Using these comps and what they've learned from visiting the home, the appraiser will prepare an appraisal report that includes a figure that represents their perceived value of the home.

A copy of this appraisal report is then shared with the buyer and the buyer's mortgage lender. It can take anywhere from a week to 10 days for the report to be completed. Sellers can also request a copy of the report.

If a buyer disagrees with the appraisal report, they can request a reconsideration from the lender or opt to pay for a second appraisal.

How To Improve Your Home's Appraisal Value

The appraisal process is meant to be objective, but appraisers are human. Good curb appeal and clean, uncluttered rooms send a message of a well- maintained home. And they can be achieved without a great deal of time or expense. There are some easy ways to quickly improve the appraised value of your home:

- Clean and uncluttered rooms convey the message that a home is well-maintained.
- Minor cosmetic improvements can make a big difference.
- Point out any major improvements you've made to the appraiser, in case they miss them.
- On the other hand, you should avoid big expensive improvements just for the sake of increasing your home's appraisal value. They generally don't pay off.

Make sure you know your rights as well. If you hire the appraiser to determine your home’s value, the appraisal belongs to you. If you’re refinancing your mortgage and the lender hires the appraiser, the lender is required to provide you with a copy–possibly for a reasonable fee–of the appraisal and any other home value estimates.

If you think the appraiser has the value wrong, first review the written appraisal for errors. Check whether the comps the appraiser chose are reasonably similar to your home. If you still think the price is incorrect, you can appeal the valuation with your lender or ask it to order a second appraisal.

How Much Does a Home Appraisal Cost?

On average, a home appraisal can cost anywhere from $300 to $450.

The price may be higher for appraisals of multi-family homes or properties that are above average in size. The buyer is most often responsible for paying appraisal fees at the time the appraisal is ordered.

Is a Home Appraisal Required?

A home appraisal is almost always a requirement when purchasing a home with a mortgage. Lenders use the appraisal to determine whether the home is worth the amount of money the buyer is asking to borrow. A buyer may not require an valuation if they're paying cash for a home versus taking out a mortgage loan.

Can the Buyer Be Present During an Appraisal?

Both buyers and sellers can ask to be present at the home appraisal with the approval of the appraiser. In lieu of attending themselves, buyers and sellers can request that their agents be allowed to attend the appraisal. But typically, only the appraiser is present as it's less common for buyers or sellers to show up.

What Happens If the Appraisal Comes in Too Low?

If a home appraisal comes in below what the buyer has agreed to pay, there are several options they could choose from. The first is to ask the seller to renegotiate the home's price so that it aligns with the home's appraisal value. The next option is to pay the difference between the appraisal value and the asking price out of pocket. Buyers could also use a piggyback mortgage to make up the difference between the home's value and its sales price.

Do I Need an Appraisal to Refinance a Mortgage?

In most cases, yes. Lenders use appraisals to determine a home's value for refinancing mortgages the way they do for purchase mortgages. There are a couple of exceptions, however. In some cases, you will not need an valuation if you are taking out an FHA refinance loan if it is what is called a "streamline" refinance loan.

If you hold a VA-backed loan, you will need an appraisal if you are planning to take out a cash-out refinance loan.

Due to the COVID- 19 pandemic, there is a partial waiver on appraisals from April 26, 2021, to April 26, 2022, according to the U.S. Department of Housing and Urban Development.

The Bottom Line

An appraisal is an assessment of the fair market value of a property, business, antique, or even a collectible. Appraisals are used to estimate the value of items that are infrequently traded and are often rare or unique. The authorized appraiser must have a designation from a regulatory body governing the jurisdiction of the appraiser. Appraisals can be done for many reasons such as tax purposes when valuing charitable donations, but the most familiar form of appraisal is for a property.

Home appraisals can positively or negatively impact the sale of a house or property, and so are an important part of the process of financing a house. A home appraisal is almost always a requirement when purchasing a home with a mortgage, for example, and if you are refinancing your property your lender may hire their own appraiser to make a valuation of your home.

L. Other Insurance Provision

Definition: An other insurance provision specifies how coverage will be apportioned if multiple insurance policies cover the same risk.

Example: If a person has two health insurance policies, the other insurance provision determines which policy pays first and how much the second policy will cover.

What Does Other Insurance Clause Mean?

An other insurance clause is a provision included in insurance policy contracts that specifies exactly how much coverage the policy offers if the insured has another policy that covers the same risk. Depending on the clause, the insurers may share coverage or one policy may be sufficient.

Other Insurance Clause

The other insurance clause is a protection against overinsurance, a situation in which multiple insurers pay out claims for the same loss. Overinsurance would allow an insured to earn a profit from their insurance policies.

Usually, one policy is assigned as the primary insurance. The primary insurance is the first coverage that will come into effect when the policyholder suffers an insured loss. If the primary policy is exhausted and has not been able to pay for the entire loss, the other policies will provide additional coverage for the remaining loss.

Policyholders are advised to read the other insurance clause carefully because it might notify them that the policy will not provide coverage if another policy covers the same risk.

M. Subrogation

Definition: Subrogation is the legal right held by insurers to pursue a third party that caused an insurance loss to the insured.

Example: After paying for damages from a car accident, an insurance company sues the at-fault driver to recover the costs.

What Is Subrogation?

Subrogation is a term describing the right held by most insurance carriers to legally pursue a third party that caused an insurance loss to an insured. This allows the insurance carrier to recover the amount of the claim it paid to the insured for the loss.

Key Takeaways

Subrogation is a term describing a legal right held by most insurance carriers to legally pursue a third party that caused an insurance loss to the insured.

In most subrogation cases, an individual’s insurance company pays its client’s claim directly, then seeks reimbursement from the other party's insurance company.

Subrogation is most common in an auto insurance policy but also occurs in property/casualty and healthcare policy claims.

Subrogation allows the at-fault party's insurer to reimburse the victim's insurance company.

The insured’s carrier will then reimburse the insured, along with any deductibles the insured paid.

Understanding Subrogation

Subrogation refers to the act of one person or party standing in the place of another person or party. It effectively defines the rights of the insurance company both before and after it has paid claims made against a policy.

Also, it makes the process of obtaining a settlement under an insurance policy easier.

When an insurance company pursues a third party for damages, it is said to "step into the shoes of the policyholder." Thus, the carrier will have the same rights and legal standing as the policyholder when seeking compensation for losses. If the insured party does not have the legal standing to sue the third party, the insurer will also be unable to pursue a lawsuit as a result.

How Subrogation Works

In most cases, an individual's insurance company pays its client's claim for losses directly, then seeks reimbursement from the other party or their insurance company. In such cases, the insured typically receives prompt payment. Then the insurance company may pursue a subrogation claim against the party at fault for the loss.

Insurance policies may contain language that entitles an insurer, once losses are paid on claims, to seek recovery of funds from a third party if that third party caused the loss. The insured does not have the right to file a claim with the insurer to receive the coverage outlined in the insurance policy or to seek damages from the third party that caused the losses.

Subrogation enables accident victims to receive claim payments more quickly after a loss.

Subrogation (sometimes shortened to "subro") in the insurance sector, especially among auto insurance policies, occurs when the insurance carrier takes on the financial burden of the insured as the result of an injury or accident payment and seeks repayment from the at-fault party. The subrogation process can take weeks, months, or even years to complete, depending on the complexity of the case, state regulations, and other factors.

Example of Subrogation

One example of subrogation is when an insured driver's car is totaled through the fault of another driver. The insurance carrier reimburses the covered driver under the terms of the policy and then pursues legal action against the driver at fault. If the carrier is successful, it must divide the amount recovered after expenses proportionately with the insured to repay any deductible paid by the insured.

Subrogation is not only relegated to auto insurers and their policyholders. Subrogation also occurs within the health care sector. If, for example, a health insurance policyholder is injured in an accident and the insurer pays $20,000 to cover the medical bills, that same health insurance company is allowed to collect $20,000 from the at-fault party to reconcile the payment.

Subrogation Process for the Insured

Luckily for policyholders, the subrogation process is extremely passive for the victim of an accident when another party is at fault. The subrogation process is meant to protect insured parties; the insurance companies of the two parties involved work largely behind the scenes to mediate and come to agreement over the payment.

Policyholders are simply covered by their insurance company and can act accordingly. The insured party benefits because the at-fault party must make a payment during subrogation to the insurer, which helps keep the policyholder's insurance rates low.

Insurance companies do most of the work during subrogation, freeing the insured from having to participate in the process.

In the case of any accident, it remains important to stay in communication with the insurance company.

Make sure all accidents are reported to the insurer in a timely manner and let the insurer know if there should be any settlement or legal action. If a settlement occurs outside of the normal subrogation process between the two parties in a court of law, it is often legally impossible for the insurer to pursue subrogation against the at-fault party. This is due to the fact most settlements include a waiver of subrogation.

Benefits of Subrogation

In insurance, subrogation allows your insurer to recover the costs associated with a claim, such as medical bills, repairs costs, and your deductible, from the at-fault party's insurer (assuming you were not at- fault). This means that both you and your insurer can recoup the costs of damage or harm caused by somebody else.

It also means improved loss ratios, profits, and underwriting revenue for the insurer, plus added customer satisfaction and protection.

Waivers of Subrogation

A waiver of subrogation is a contractual provision where an insured waives the right of their insurance carrier to seek redress or compensation for losses from a negligent third party. Typically, insurers charge an additional fee for this special policy endorsement. Many construction contracts and leases include a waiver of subrogation clause.

Such provisions prevent one party’s insurance carrier from pursuing a claim against the other contractual party in an attempt to recover money paid by the insurance company to the insured or to a third party to resolve a covered claim. In other words, if subrogation is waived, the insurance company cannot "step into the client's shoes" once a claim has been settled and sue the other party to recoup their losses. Thus, if subrogation is waived, the insurer is exposed to greater risk.

What is the Legal Definition of Subrogation?

Subrogation, in the legal context, refers to when one party takes on the legal rights of another, especially substituting one creditor for another. Subrogation can also occur when one party takes over another's right to sue.

Does Subrogation Affect the Insured Victim?

The subrogation process, which is meant to protect insured parties, is a passive experience for the insured victim of an accident when another insured party is at fault. The insurance companies of the two parties involved work to mediate and legally come to a conclusion over payment. The insured benefits when the at-fault party makes payment during subrogation to the insurer, which helps keep the policyholder's insurance rates low.

How Does Subrogation Affect Claims Payments?

Subrogation allows the accident victim's insurance company to pay claims immediately to their client, allows the insured to receive payments more quickly. Their insurance carrier then seeks to recover that amount from the at-fault party or their insurer.

The Bottom Line

Subrogation allows insurance carriers to legally pursue claims against a third party that caused an insurance loss to one of its insureds. This enables the insurer to pay claims files by its insurers sooner, and then recover the claim amount from the parties who are at fault for the loss. Subrogation allows insured to receive payments sooner and helps keep their premiums low.

N. Elements of a Contract

Definition: The essential elements of a contract include offer, acceptance, consideration, capacity, and legality.

Example: A contract for the sale of a car includes an offer (price), acceptance (agreement to buy), consideration (payment), capacity (legal ability to contract), and legality (lawful purpose).

ELEMENTS OF A CONTRACT

To be valid, a contract must generally contain all of the following elements:

- Offer
- Acceptance
- Consideration
- Legality

OFFER:

Contracts always start with an offer. An offer is an expression of a willingness to enter into a contract on certain terms. It is important to establish what is and is not an offer. Offers must be firm, not ambiguous, or vague. A person who is making the offer is called the offeror.

Invitation to Treat: Offers are different than an invitation to treat. An invitation to treat is not an offer. When you list your home for sale, you are not making an offer; you are making an offer to treat. You are inviting potential buyers to make an offer to you to buy your home. The same is true with most advertising. The stores are making an offer to treat. They are expressing their willingness to sell you something if you offer them their asking price. However, they are not bound to accept your offer. For example, you place an ad online to sell your automobile for a certain price. Someone makes an offer to buy the automobile from you at full price. Do you have to accept their offer? No. You are making an offer to treat, and you are not bound to accept their actual offer to buy your automobile.

Puffery: Advertisers often use puffery to promote their products. So, was the advertising slogan “Red Bull Gives You Wings” meant to be a true statement or puffery? In a class action lawsuit filed on Jan. 16, 2013, in the

U.S. District Court of the Southern District of New York by Benjamin Careathers, Mr. Careathers claimed he had been drinking Red Bull since 2002. His lawsuit argued that Red Bull mislead consumers about the superiority of its products starting with its slogan “Red Bull gives you wings” and its claims of increased performance, concentration, and reaction speed. Red Bull eventually settled the lawsuit for 13 million dollars. Red Bull maintains that its marketing and labeling have always been truthful and accurate and denies any and all wrongdoing or liability.”

Courts will determine whether a statement in advertising is false versus puffery by using the "reasonable person" standard. In other words, would a reasonable person believe the exaggerated statement in an advertisement is meant to be true? It is hard to imagine a jury would find that the Red Bull advertisement that by drinking their product one would grow wings was anything but puffery.

Counter-Offers: A counter-offer negates the original offer. It alters the original offer, and by doing, so releases the person making the original offer from any obligation. For example, A makes an offer to treat regarding the sale of A's automobile for $10,000.00. B offers A $9,000.00. If A accepts this offer, B is bound to purchase the vehicle for that price. A does not have to accept B's offer and is not bound to. However, A then makes a counter- offer to B that A will sell the vehicle for $9,500.00. B is not bound to buy the vehicle for that price, but A is now bound to sell the vehicle to B for that price if B accepts the counter-offer.

ACCEPTANCE:

Acceptance by the offeree (the person accepting an offer) is the unconditional agreement to all the terms of the offer. There must be what is called a "meeting of the minds" between the parties of the contract. This means both parties to the contract understand what offer is being accepted. The acceptance must be absolute without any deviation, in other words, an acceptance in the "mirror image" of the offer. The acceptance must be communicated to the person making the offer. Silence does not equal acceptance.

CONSIDERATION:

Consideration is the act of each party exchanging something of value to their detriment. A sells A's automobile to B. A is exchanging and giving up A's automobile while B is exchanging and giving up B's cash. Both parties must provide consideration.

Past Consideration: Voluntarily doing something for someone is not consideration. A sees B's lawn needs to be cut so A voluntarily does so. B comes home from work and is so pleased that B gives A $30 for cutting the lawn. The following week A cuts B's lawn again without B asking A to do so. A now asks B for $30 for cutting the lawn and B refuses to do so.

A claims they have a contract since A has provided consideration by mowing B's lawn, even though it was voluntary. A is incorrect. B is not obligated to provide consideration to A. There is no contract.

However, if B had asked A to mow the lawn, but did not set the price, A would probably be able to enforce the contract after mowing the lawn because B requested he does so.

Performance of an Existing Duty: If a person has a duty to do something, such as a public servant, the performance of the duty is not consideration.

Promissory Estoppel: In some instances, one party is not providing consideration but is relying on a reasonable promise made by another. A party that is induced to action based on a reasonable promise may be able to enforce the promise under the legal theory of promissory estoppel.

A promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee or a third person and which does induce such action or forbearance is binding if injustice can be avoided only by enforcement of the promise. The remedy granted for breach may be limited as justice requires.

A charitable subscription or a marriage settlement is binding under Subsection (1) without proof that the promise induced action or forbearance.

For example, A works for B who has promised to provide A retirement benefits if A works for B for 25 years. After A is employed with B for 15 years, B tells A that the retirement benefits will now be half the amount originally promised. A can enforce the original promise under the theory of promissory estoppel even though A has provided no consideration. A can make the case that A was induced and acted on this promise.

LEGALITY:

The fourth required element of a valid contract is legality. The basic rule is that courts will not enforce an illegal bargain. Contracts are only enforceable when they are made with the intention that they are legal and that the parties intend to legally bind themselves to their agreement. An agreement between family members to go out to dinner with one member covering the check is legal but is not likely made with the intent to be a legally binding agreement.

Just as a contract to buy illegal drugs from a drug dealer is made with all the parties knowing that what they are doing is against the law and therefore not a contract that is enforceable in court.

Lack of Mental Capacity: The capacity to enter into a contract may be compromised by mental illness or intellectual deficiency. Issues of dementia and Alzheimer's can blur the lines of competency to sign a contract. Competency to enter into a contract requires more than a transient surge of lucidity. It requires the ability to understand not only the nature and quality of the transaction but an understanding of its significance and consequences. If a person is found to lack the mental capacity to enter into a contract, then the contract is not automatically void but it is voidable.

Minors and Contracts: Minors under the age of 18 years old are allowed to sign contracts, but they are voidable at the minor's election. The exception to this rule is that contracts for necessities are not voidable.

Necessities are general goods or services necessary for subsistence, health, comfort, or education. The burden to prove a contract is for necessities for a minor is on the plaintiff. Minors can affirm their contract made while a minor formally or by actions upon reaching the age of 18.

Contracts That Must Be In Writing: As already mentioned above, not all contracts have to be in a written format. However, some absolutely do, or they are voidable. Under the common law doctrine of the "Statute of Frauds," which has been codified in the General Obligations Law (GOB), contracts for the purchase of real property (GOB § 5-703), contracts that cannot be performed in less than 1 year, and contracts that guarantee the debt of another (co-signers) (GOB § 5-701) must all be in writing. It is important to understand that just about any form of writing is acceptable. A handwritten contract to purchase real property on a napkin is acceptable if all the elements of a contract are met. The use of email and text messages may also be acceptable under GOB § 5-701(4).

UNILATERAL VERSUS BILATERAL CONTRACTS:

Most contracts are **bilateral**, meaning both parties are in agreement and the four basic elements of a contract exist. For example, B offers to buy A's automobile for a specific price and A accepts the offer and agrees to give B the automobile upon receipt of those specific funds.

Both parties are agreeing to the contractual arrangement. It is bilateral.

In a **unilateral** contract, one party is making an offer and promise if someone does something in return. There is no agreement necessarily between two individuals as there is in a bilateral contract. However, an offer is made and if another individual accepts the offer and performs, an enforceable contract exists.

An example would be if A offers a reward of $100 to the person who finds and returns A's missing cat. If B finds and returns the cat to A, A would be bound to pay B the $100 reward. This is a unilateral contract.

O. Warranties, representations, and concealment

Warranties

Definition: Warranties are promises made by the insured that certain conditions will be met.

Example: A warranty in a marine insurance policy might require the insured to maintain the vessel in seaworthy condition.

Representations

Definition: Representations are statements made by the insured during the application process that are believed to be true.

Example: Stating that you have a home security system when applying for homeowner's insurance is a representation.

Concealment

Definition: Concealment is the intentional withholding of information by the insured that is material to the risk.

Example: Failing to disclose a previous heart condition when applying for life insurance is concealment.

P. Sources of Underwriting Information

Definition: Underwriting information is gathered from various sources to assess the risk of insuring a person or entity.

Example: An insurance company uses credit reports, medical records, and driving history to underwrite a life insurance policy.

What is Underwriting?

Underwriting is the process that a lender or other financial service uses to assess the creditworthiness or risk of a potential customer.

Underwriting also refers to an investment banker's process of packaging and selling a security on behalf of a client.

How Does Underwriting Work?

Underwriting refers to the structured process used by financial service companies, such as banks, investors, or insurers, to determine and price the risk from a potential client. The underwriting process is a detailed and systematic analysis of a potential borrower's creditworthiness, including employment history, salary, financial statements and performance, publicly available information, and independent credit reports. The underwriting process is intended to determine the credit needs, the quality of the collateral assets to be used to support the borrowing, and the borrower's ability to repay the debt. Upon completion of a formal underwriting process and a summary presented to a credit committee within the lender, the lender will either approve or reject the request for a loan.

Similarly, an insurance company will evaluate the risks of a potential candidate for insurance, based on a variety of actuarial factors. The bottom line from such an underwriting process is to price the insurance in accordance with its associated risk.

In securities trading, underwriting also includes assessing the risk and pricing the security accordingly. However, the formal underwriting process also involves agreeing to buy the security (by the underwriter) and then selling the security for a profit. The underwriter effectively takes a risk by agreeing to buy the security at the established price. In most instances, underwriters will line up buyers for the securities before they take on the security, so that it can 'flip' the security to the buyer immediately.

Why Does Underwriting Matter?

Underwriting is a critical step in the credit analysis and risk pricing process for almost all financial service companies. For companies, understanding the underwriting process and the requirements at each stage of the process will allow a company to prepare and present itself accordingly. For investors, the information contained in an underwriting is crucial to understanding the risks and potential rewards from a security's underlying asset.

Q. Fair Credit Reporting Act (FCRA)

Definition: The FCRA is a federal law that promotes the accuracy, fairness, and privacy of information in consumer credit reports.

Example: A consumer disputes an error on their credit report, and the credit bureau must investigate and correct it if necessary.

The Fair Credit Reporting Act (FCRA), 15 U.S.C. § 1681 et seq., is federal legislation enacted to promote the accuracy, fairness, and privacy of consumer information contained in the files of consumer reporting agencies. It was intended to shield consumers from the willful and/or negligent inclusion of erroneous data in their credit reports. To that end, the FCRA regulates the collection, dissemination, and use of consumer information, including consumer credit information.[1] Together with the Fair Debt Collection Practices Act (FDCPA), the FCRA forms the foundation of consumer rights law in the United States.

It was originally passed in 1970,[2] and is enforced by the U.S. Federal Trade Commission, the Consumer Financial Protection Bureau, and private litigants.

R. Privacy Protection (Gramm-Leach-Bliley Act)

Definition: The Gramm-Leach-Bliley Act requires financial institutions to explain their information-sharing practices and protect consumers' private information.

Example: A bank provides customers with a privacy notice explaining how their personal information is shared and how they can opt out.

S. Policy Application

Definition: A policy application is a form used by an applicant to request insurance coverage.

Example: An individual fills out a policy application to apply for auto insurance, providing details about their driving history and vehicle.

T. Terrorism Risk Insurance Act (TRIA)

Definition: TRIA is a federal law that provides a government backstop for insurance claims related to acts of terrorism.

Example: After a terrorist attack, TRIA ensures that insurance companies can cover the losses without going bankrupt.

The Terrorism Risk Insurance Act (TRIA) (H.R. 3210, Pub. L.Tooltip Public Law (United States) 107–297 (text) (PDF)) is a United States federal law signed into law by President George W. Bush on November 26, 2002. The Act created a federal "backstop" for insurance claims related to acts of terrorism. The Act "provides for a transparent system of shared public and private compensation for insured losses resulting from acts of terrorism."[1] The Act was originally set to expire December 31, 2005, was extended for two years in December 2005, and was extended again on December 26, 2007. The Terrorism Risk Insurance Program Reauthorization Act expired on December 31, 2014.[2]

U. Territory

Definition: The territory provision in an insurance policy defines the geographic area where coverage applies.

Example: An auto insurance policy specifies that coverage is valid only within the United States and Canada.

Key Takeaways

Insurance coverage territory varies depending on the type of policy being discussed.

It refers to the geographic area where coverage applies.

In most cases, coverage territory includes the United States, its territories and possessions, Puerto Rico, and Canada.

When a policy does not specify a coverage territory, it is generally assumed to apply worldwide.

IV. CASUALTY: TYPES OF POLICIES, BONDS, AND RELATED TERMS

A. Commercial General Liability (CGL)

Commercial General Liability (CGL) insurance is a crucial aspect of protecting businesses from a variety of liabilities. It provides coverage for a range of potential risks that may arise in the course of business operations.

1. Exposures

a. Premises and Operations

Premises and Operations Liability: This aspect of CGL insurance covers bodily injury or property damage that may occur on the insured's premises or as a result of their operations. For example, if a visitor slips and falls in a retail store, the CGL insurance would cover any resulting medical expenses or legal fees.

b. Products and Completed Operations

Products and Completed Operations Liability: This coverage extends to bodily injury or property damage caused by products sold or work completed by the insured. For instance, if a faulty product sold by a business causes harm to a consumer, the CGL insurance would cover any resulting legal costs or damages.

c. Contractual Liability

Contractual Liability: This aspect of CGL insurance covers liabilities assumed by the insured under contract. For example, if a business enters into a contract that holds them responsible for certain damages, the CGL insurance would provide coverage in case of a lawsuit.

Personal and Advertising Liability:

Personal and Advertising Liability: This coverage protects against liabilities related to defamation, copyright infringement, or other advertising-related claims. For example, if a competitor sues a business for making false claims in their advertising, the CGL insurance would cover any resulting legal fees or damages.

Medical Payments:

Medical Payments: This coverage provides for medical expenses for injuries sustained on the insured's premises or as a result of their operations, regardless of fault. For example, if a customer is injured in a store, the CGL insurance would cover their medical bills.

Owners and Contractors Protective Liability:

Owners and Contractors Protective Liability: This coverage provides liability protection for property owners or contractors who may be held responsible for the actions of their subcontractors. For example, if a subcontractor causes property damage while working on a project, the CGL insurance would provide coverage.

Occurrence Coverage:

Occurrence Coverage: This type of coverage provides for claims that occur during the policy period, regardless of when they are reported. This is important as some claims may not be made immediately after an incident occurs.

Claims Made Coverage:

Claims Made Coverage: This coverage provides protection for claims made during the policy period, regardless of when the incident occurred. This ensures that businesses are covered for claims that may arise even after the policy has expired.

Overall, CGL insurance is essential for businesses to protect themselves from a wide range of liabilities that may arise in the course of their operations. By understanding the different aspects of CGL coverage and how they apply to specific scenarios, businesses can ensure they have the necessary protection in place.

Commercial General Liability

Objectives: In this section we'll cover the commercial general liability coverage. This provides coverage for claims for which businesses or commercial enterprises may become legally liable. The following will be covered:

Basic Hazards: Premises and Operations, Products and Completed Operations, Independent Contractors, and Insured Contracts

Commercial General Liability coverage forms:

Coverage A – bodily injury and property damage,

Coverage B - personal injury and advertising injury liability, and

Coverage C - medical payments

Supplementary payments

Occurrence form and claims made form

Definition of "the insured"

Limits of liability

Conditions

Definitions

In the course of doing business, businesses interact with employees, contractors, clients, vendors, and others. Any one of these could claim that your business caused them injury or loss and take legal action against you.

Commercial general liability is a standard insurance policy that provides liability coverage for a business. This can be included as part of a Commercial Package Policy or as a standalone policy.

Commercial general liability protects against claims for bodily injury, property damage, personal injury or advertising injury arising out of premises, operations, products, and completed operations the insured becomes legally liable to pay to others due to negligence or failure to act in a reasonable manner. It also covers medical payments to others without the need to prove negligence or admission of fault.

Basic Hazards

The following basic hazards covered by Commercial General Liability insurance are described below:

- Premises and Operations liability
- Products and Completed Operations liability
- Independent Contractors liability

- Insured Contracts liability

Premises and Operations

Premises and Operations coverage pays for bodily injury or property damage that occurs on your premises or as a result of your business operations offsite or on the premises of a client.

Premises liability:

Provides coverage for bodily injury or property damage if someone is injured or property is damaged on your own fixed premises

The premium is based generally on the size of the premises and how much is accessible to the public

Premises includes the parking lot and sidewalk adjacent to your building

This would cover your liability if, for example, a customer slipped and fell on your premises because the floor was wet. This would also cover any liability for property damage to someone else's property that occurred on your premises.

Operations liability:

Provides coverage for bodily injury or property damage if someone is injured or property is damaged, and the occurrence is the result of your business operations

The premium is based on your payroll. The premium increases the more employees you have on your payroll.

This coverage is required, for example, if you are a building contractor and require coverage for your building operations on multiple sites, or if you are a professional consultant and work at client sites.

Products and Completed Operations

Products and Completed Operations coverage pays for bodily injury or property damage that occurs away from your business premises and is caused by your products or completed work.

Products liability:

Provides coverage for bodily injury or property damage if someone is injured or property is damaged as a result of a product you either manufacture or sell

Coverage applies to a faulty product only after it is released from the control of the manufacturer or retailer, that is, after it has left their premises or been delivered.

The loss or damage to the product itself is not covered. Only bodily injury or property damage caused by the product is covered.

The cost of a recall of a faulty product and any resultant loss of income as a result of the recall is not covered.

The premium for products liability is based on gross annual sales of the product.

This coverage could apply to either or both the manufacturer or retailer if someone is injured by a product they had purchased.

Completed Operations liability:

Provides coverage for bodily injury or property damage if someone is injured or property is damaged as a result of work you have performed, whether it is built or a service provided.

Coverage applies only after the work has been completed. Coverage while the work is being performed would be covered under the operations liability.

If there is damage or loss due to faulty construction, such as a deck or roof collapsing, this would be covered under Completed Operations liability if it were found that the insured were legally liable due to negligence.

Independent Contractors

A business may be held liable for the actions of independent or sub-contractors it uses. The Commercial General Liability policy can provide coverage for the insured for the work or actions of these independent contractors.

This insurance coverage is also known as Contingent Liability coverage and can be provided by Owners and Contractors Protective insurance.

For example, a business operates as a general contractor and utilizes sub-contractors to perform their construction work for them. If the sub-contractor is negligent and someone suffers bodily injury as a result, the business owner, the insured, could become legally liable for damages to the injured party. Generally, the business would require independent contractors to have their own liability coverage, but with this Contingent Liability coverage, the insured would have insurance protection if they are found to be legally liable.

Insured Contracts

The Commercial General Liability coverage will cover liability that is assumed by the insured for specific insured contracts defined in the policy. This also falls under the definition of Contingent Liability and is known as Contractual Liability.

The following contracts are considered insured contracts under the Commercial General Liability coverage:

A contract for lease of premises. The owner of the leased premises would very likely require the insured to be liable for any bodily injury or property damage suffered on the premises or as a result of their business operations and would require the lessee to have liability coverage. This would be provided by this Contractual Liability. The lessor and the lessee would have an agreement, known as a “Hold Harmless Agreement”, that the lessor would not be liable for any of these damages.

A sidetrack agreement, (also known as a railroad siding). If a business uses the railroad system to transport its products, the railroad may build a siding on the business property, but they would require the business owner to take responsibility for any liability arising out of bodily injury or property damage caused by the siding on their property. The railroad would require a “Hold Harmless Agreement” from the business owner. The Commercial General Liability coverage will provide the business owner, the insured, with this liability coverage under its Contractual Liability.

An easement or license agreement, but excluding construction or demolition on or within 50 feet of a railroad

An obligation or legal requirement to indemnify a municipality, except for work the municipality performs

An Elevator maintenance agreement. Similar to the other contractual liability coverages, an elevator maintenance company may require the insured to cover any liability arising from the use of the elevators on their business premises.

Commercial General Liability Coverage Forms

2. Coverage

The following are the Commercial General Liability coverage forms and will be described in more detail below:

Coverage A: Bodily Injury and Property Damage liability

Coverage B: Personal Injury and Advertising Injury liability

Coverage C: Medical Payments

a. Coverage A: Bodily Injury and Property Damage Liability

Coverage A provides bodily injury and property damage coverage for Premises and Operations liability and for Products and Completed Operations liability.

If it was proved that you were negligent and were liable to pay damages, the insurance company would cover your liability up to the limit of liability on the policy. The insurer would also cover the cost of defense. The cost of defense is in addition to the limit of liability. Generally there is no deductible for liability insurance.

Coverage is provided on an occurrence basis and would be subject to an occurrence limit.

Exclusions:

The following exclusions apply to Coverage A – Bodily Injury and Property Damage liability:

- Liability arising out of expected or intentional injury
- Liability the insured assumes under a contract or agreement unless the liability would be there without assuming it under the contract or the contractual coverage is specifically stated in the policy.
- Liquor liability if the insured is in the beverage business, that is, manufactures, distributes, sells, or serves alcoholic beverages.
- Work-related liability covered by workers' compensation or employer's liability
- Liability related to pollution or the cost of pollutant cleanup
- Liability arising out of the ownership, use, loading or unloading of an aircraft, auto, or watercraft
- Liability arising out of the transportation of mobile equipment by auto or the use of mobile equipment in a prearranged racing or related activity
- Liability arising out of war or warlike acts
- Damage to the insured's own property or any property in the care, custody, or control of the insured
- Damage to the insured's own product or damage that arises out of the insured's product or its parts

- Damage to the insured's work that is covered in the Products and Completed Operations hazard. This exclusion does not apply to work performed by a subcontractor.
- Liability for claims based on defects, deficiencies, inadequacies, or dangerous conditions in the insured's products and work and delays or failure to properly perform contracts
- Liability related to recall of an insured's products or work because of a known or suspected defect
- Liability for bodily injury arising out of personal or advertising injury
- Liability arising out of loss or damage to electronic data
- Liability arising out of violations of the Telephone Consumer Protection Act or the CAN-SPAM act as it applies to unsolicited emails

Fire Legal Liability

The landlord of leased premises may require the business who is leasing their premises to take responsibility for property damage caused by fire as a result of their negligence. To accomplish this, Fire Legal Liability can be provided by overriding the exclusion related to damage of the insured's own property or any property in the care, custody, or control of the insured by fire. Note that this covers loss or damage by fire only. This coverage is very common in commercial lease agreements.

Pollution Coverage

Liability for bodily injury or property damage as a result of pollution is excluded under the Commercial General Liability coverage. If the insured requires coverage for liability arising out of pollution, they have three options:

Pollution liability coverage extension endorsement:

This endorsement removes the exclusion for liability arising out of bodily damage or property damage as the result of pollution.

It does not, however, cover the cost of pollutant clean-up

Pollution liability coverage form:

This coverage form provides coverage for certain pollution losses that are excluded under the Commercial General Liability form

Coverage is provided for pollution incidents which are emissions of pollutants into or onto the land, the atmosphere, or water that cause environmental damage

Coverage is written on a claims-made form

Coverage is provided for designated sites and separate limits of liability are specified in the Declarations

This coverage form includes the costs of pollutant clean-up

Pollution liability – limited coverage form:

This is a coverage form similar to the Pollution liability coverage form but does not include the costs of pollutant clean-up

b. Coverage B: Personal Injury and Advertising Injury

Coverage B provides coverage for financial liability arising out of offenses related to Personal Injury or Advertising Injury. Personal Injury includes such offenses as libel, slander, malicious prosecution, invasion of privacy, and false arrest. Advertising Injury includes such offenses as copyright infringement and use of advertising ideas without permission.

Coverage is provided on a per person basis and would be subject to a per person limit.

Exclusions

The following exclusions apply to Coverage B – Personal Injury and Advertising Injury liability:

- Knowingly violating another's rights or inflicting personal or advertising injury
- Oral or written publication of material that the insured knows is false and publishes it anyway
- Material that was published before the effective date of the policy
- Criminal acts committed by or at the direction of the insured
- Liability assumed under a contract unless the liability would have been incurred even without assuming it under the contract
- Breach of contract. Your failure to adhere to the terms of a contract. Coverage is provided for breach of an implied contract to use someone else's advertising idea in your advertisement.
- Failure of goods, products, or services to conform with advertised quality or performance
- Incorrect price descriptions of goods, products, or services
- Any offense committed by an insured who is in the business of advertising, publishing, broadcasting, telecasting, or designing or determining content of websites for others
- Infringement of copyright, patent, trademark, trade secret, or other intellectual property rights. An exception to this exclusion is an infringement in your advertisement of someone else's copyright, trade dress or slogan
- Any internet chat rooms or bulletin boards the insured owns or hosts or has control over or the use of someone else's email address or domain name without authorization
- Liability arising out of war or warlike acts
- Liability arising out of violations of the Telephone Consumer Protection Act or the CAN-SPAM act as it applies to unsolicited emails

c. Coverage C: Medical Payments

Medical Payments coverage is designed to minimize the cost of responding to accidents resulting in bodily injury and avoid expensive lawsuits.

Coverage C – Medical Payments coverage is provided on the following basis:

- It covers necessary medical expenses that are the result of bodily injury that occurs on or next to the premises the insured owns or rents or injury that occurs as a result of the insured's business operations
- The insurer agrees to make these payments regardless of fault within the limits of insurance included in the policy. Legal liability due to negligence is not considered under Medical Payments.
- It is intended to allow the insured to react promptly to accidents without consideration of fault
- The accident must occur in the coverage territory and during the policy period
- Medical expenses must be incurred and reported to the insurer within one year after the accident
- Coverage is on a per person basis

There is no payment for property damage or loss

Medical expense will pay reasonable expenses for:

- First aid when the accident occurs
- Medical and surgical services
- Hospital expenses
- X-ray services
- Ambulance services
- Professional nursing services
- Dental services
- Funeral services

Medical expenses are paid to "others" and so would not be paid for the following:

- Any insured (other than a volunteer worker)
- Anyone hired to work for or on behalf of any insured or any insured's tenant
- A person injured on premises the insured owns or rents and who normally occupies the premises
- A person whose injury is covered by other insurance such as workers' compensation, disability insurance, or other insurance specified by law
- A person injured while taking part in athletics
- Injuries covered by the Products and Completed Operations hazard. Individuals injured by the insured's products or work would have to demonstrate legal liability of the insured for that injury and try to collect under Coverage A.

Coverage A exclusions.

This is a simple way for the Commercial General Liability policy to define the limits of Medical Payments coverage. In other words, Coverage C looks to the overall Insuring Agreement of Coverage A to determine the applicability of coverage. No coverage will apply, for example, for auto accidents or intentional injuries.

Related to war or warlike acts. War includes civil war, insurrection, rebellion, or revolution.

d. Supplementary Payments

Supplementary payments are a provision in liability policies for the costs associated with the investigation and resolution of claims. Commercial General Liability policies cover supplementary payments in addition to their limits of liability.

Supplementary payments apply only to Coverages A and B. Coverage C – Medical Payments does not require defense against a liability claim and therefore these costs would not apply.

In addition to the limits of insurance paid for legal liability, the insurer will cover the following supplementary payments:

- Expenses the insurance company incurs
- Up to $250 for the cost of bail bonds required because of an accident, including related traffic law violations. The accident must result in bodily injury or property damage covered under the policy.
- Cost of bonds to release attachments, up to the limit of insurance
- Reasonable expenses the insured incurs at the insurance company's request to assist in investigating or defending a claim or suit, including $250 a day for lost earnings because of time off work
- Costs the insured is required to pay because of a suit. This does not include attorney's fees.
- Prejudgment interest the insured is required to pay, unless the insurance company makes an offer to pay the limit of insurance, and then it will not pay prejudgment interest based on the period after the offer
- Interest that accrues after a judgment and before it is paid, offered, or deposited in court

The Occurrence Form and the Claims Made Form

Commercial General Liability coverage can be provided by one of two coverage forms, an occurrence form or a claims-made form. The two forms are essentially the same. The difference, however, is how coverage is activated or "triggered".

Occurrence Form:

Coverage is provided or triggered for liability arising out of an occurrence that takes place during the policy period and within the covered territory

The loss can be reported and claimed at any time in the future

Suppose a contractor had Commercial General Liability coverage in 1950. The contractor used asbestos in their construction at this time. Years later, someone who had lived in the house at the time developed asbestosis or mesothelioma and sued the contractor.

The insurance company would be required to cover the contractor's liability because the injury or loss occurred when the policy was in force, that is, within the policy period. Even if the policy was no longer in effect, the claim would be honored.

Claims-Made Form:

Coverage is provided or triggered for liability when a claim is filed against the insured during the policy period.

The policy can specify a Retroactive Date. The Retroactive Date can be a date prior to the policy's effective date and is specified in the Declarations of the policy. This date is agreed by the insured and the insurer. If the loss occurred prior to the specified Retroactive Date, the insurer would not cover the loss.

The Claims-Made form provides for an Extended Reporting Period whereby a claim can be filed and will be covered after the policy expiration date.

Extended Reporting Period

The Extended Reporting Period extends the time in which a claim can be reported to the insurer. This is known as tail coverage. The policy period itself is not extended. The incident must have occurred after the retroactive act or within the policy period.

The policy provides an extended reporting period under the following circumstances:

The policy is cancelled or not renewed

The policy is renewed or replaced with an advanced retroactive date, that is the retroactive date on the new policy is later than the retroactive date on the policy being replaced or renewed

The policy is replaced or renewed with a policy written on an occurrence form There are two types of Extended Reporting Periods (ERPs):

A Basic Extended Reporting Period:

Starts at the end of the policy period and provides an additional 60 days in which a claim can be reported for an incident that occurred after the retroactive date and the claim was made during the policy period

The claimant can also report a claim up to five years after the policy period as long as the notice of the pending claim was reported within the 60 days after the end of the policy period

The Basic Extended Reporting Period is provided automatically and there is no additional premium payable

A Supplemental Extended Reporting Period:

- The Supplemental Extended Reporting Period extends the reporting period indefinitely
- A premium is charged for the Supplemental Extended Reporting Period.
- The insured must purchase the Supplemental Extended Reporting period within 60 days

after the policy end date

- The additional premium may not exceed 200% of the annual Commercial General Liability policy premium
- The Supplemental Extended Reporting period cannot be cancelled and the premium is not refundable

Considerations in writing, renewing, or replacing a liability policy

In writing a policy, renewing a policy, or replacing a policy for a client, an agent must take into account past and future coverage to ensure that there are no gaps in coverage or that there are no unnecessary coverage overlaps. Some scenarios follow:

If a policy written on an occurrence form is replaced at renewal with a policy written on a claims made form, the retroactive date will be the effective date of the new policy. To set the retroactive date earlier than this, would create overlapping coverage.

If you renew a claims-made policy with a claims-made policy, the retroactive date of the new policy should be set to retroactive date of the original policy. This will eliminate any gaps in coverage from the time the insured had coverage.

In the above scenario, if the retroactive date is advanced, that is, the original retroactive is not used in the new policy, the insured must be informed of this potential gap in coverage and offered the option to have an extended reporting period.

If a policy written on a claims-made form is replaced with a policy written on an occurrence form, there may be a gap in coverage. An incident that occurred prior to the effective date of the new occurrence form and not reported within the policy period of the claims-made from being replaced would not be covered. Under the occurrence form, the incident must occur within the policy period. The extended reporting period provided under the claims-made form will address this. As described above, this can be a basic or supplemental extended reporting period.

e. Who is an insured

The insured is a specifically named individual or firm, usually the policyholder, with whom the insurance contract is made and whose interests are protected under the policy.

The definition of who “the insured” is depends on the designation of the named insured in the Declarations of the Commercial General Liability policy. The following table provides the definition of “the insured” by designation:

Designation	Definition of the insured	Restrictions
Individual or sole proprietor	Named insured Named insured’s spouse	

Partnership or joint venture	Named insured Named insured's spouse Named insured's partners and their spouses Named insured's members and their spouses	Only in connection with conducting the business
Limited liability company	Named insured Members Managers	Members are considered insured only in connection with conducting the business and managers are considered insured only in connection with their duties as managers of the business
Organization other than partnership, joint venture, or limited liability company	Named insured Executive officers and directors Stockholders	Executive officers and directors are considered insured only in connection with conducting the business and stockholders are considered insureds only in connection with their liability as stockholders
Trust	Named insured Trustees	Trustees are considered insured only in connection with their duties as trustees of the business

In addition to the above, the following are also included as insured under the Commercial General Liability policy:

- Named insured's employees when acting within the scope of their employment. This does not include executive officers, directors or managers of the business.
- The insured's volunteer workers while performing duties related to the insured's business
- Organization or individual acting as the insured's real estate manager

If the named insured dies:

- A person or organization who has temporary custody of the insured's property until a legal representative has been appointed while acting within this capacity
- The insured's legal representative while acting within this capacity

Coverage is automatically provided for newly acquired or formed organizations as a named insured under the following conditions:

- The named insured must maintain ownership or a majority interest in the new organization
- There must be no other similar insurance available to the new organization
- Coverage will be provided for 90 days or up to the policy end period, whichever is earlier. The insured would have to include coverage for the new organization after this.
- Coverages A and B do not cover losses that occurred before the organization was acquired or formed
- Automatic coverage is not provided if the newly acquired or formed organization is a partnership, joint venture, or limited liability company.

f. First Named Insured

Definition: The first named insured is the primary individual or entity listed on the policy and has the authority to make changes, file claims, and receive communications from the insurer.

Example: In a business insurance policy, the business owner listed first is the first named insured and has the authority to manage the policy.

g. Limits (Per Occurrence, Annual Aggregate)

Definition: Limits refer to the maximum amount the insurer will pay for covered losses, either per occurrence (per individual claim) or annually (total claims within a policy year).

Example: A policy with a per occurrence limit of $1 million and an annual aggregate limit of $2 million will pay up to $1 million for each claim and up to $2 million in total claims within a year.

Limits

The Limits of Insurance are the most the insurer will pay regardless of the number of occurrences, persons, or claims. These are specified in the Declarations. There are several different limits of insurance specified in the Commercial General Liability policy, including:

The General Aggregate limit. This is the most the insurer will pay in the policy period toward damages for Coverages A, B and C other than damages for Products and Completed Operations. This limit is reset at the start of a new policy period.

The Products and Completed Operations Aggregate limit. This is the most the insurer will pay in the policy period toward damages under Coverage A for bodily injury or property damage related to the Products and Completed Operations hazard. Note that this is a separate limit and does not reduce the policy's general aggregate limit.

The Personal and Advertising Injury limit. This is the most the insurer will pay under Coverage B to any one person or organization. This limit is subject to the general aggregate limit.

The Per Occurrence limit. This is the most the insurer will pay under Coverages A and C towards bodily injury or property damage or medical payments for any one occurrence. This limit is subject to the general aggregate limit or the Products and Completed Operations aggregate limit, whichever is applicable.

The Damage to Premises Rented to the Insured limit is the most the insurer will pay under Coverage A for fire damage to premises rented to the insured arising out of any one fire. This limit is subject to the Per Occurrence limit and the general aggregate limit.

Medical Expense limit. This is the most the insurer will pay under Coverage C for medical expenses because of bodily injury for any one person. This limit is subject to the per occurrence limit and the general aggregate limit.

Supplementary payments are paid in addition to the limits of insurance.

If the insured purchases the Supplemental Extended Reporting Period for a policy based on the claims- made form, separate aggregate limits apply to claims reported and recorded during the supplemental extended reporting period.

h. Damage to Property of Others Conditions

Definition: These conditions outline the insurer's responsibilities and the insured's obligations when damage occurs to property owned by others.

Example: If an insured's employee damages a customer's property while performing work, the policy conditions will detail how the insurer will handle the claim and any responsibilities of the insured.

Conditions

The Conditions section of the policy contains the rules of conduct, the rights and duties of both the insurer and the insured in providing coverage under the policy. To activate coverage under the Commercial General Liability form, the insured must follow all the applicable conditions.

The conditions include:

- Duties of the insured in the event of a claim
- How coverage will apply if there is other collectible insurance. Coverage can be written either on a primary or excess basis. If coverage is written on a primary basis and there is other primary insurance coverage, the loss is shared either based on contribution or by limit of liability.
- The right of the insurer to audit the insured’s books and records
- The insurer’s rights of subrogation. The insured agrees to transfer to the insurer any rights to recover any payments the insurer has made on behalf of the insured.
- Non-renewal of the policy. The insurer must notify the first named insured in writing that the policy will not be renewed at least 30 days before the policy expiration date.

Definitions

The definitions section of the Commercial General Liability policy clarifies important terms used in the contract. Some important definitions that are included follow:

Auto: A land motor vehicle, trailer, or semitrailer, including any attached machinery or equipment, that is:

- Designed for travel on public roads

- Subject to compulsory or financial responsibility laws or other motor vehicle laws
- Does not include mobile equipment (defined below)

Mobile Equipment: Includes any of the following types of land vehicles, including any attached machinery or equipment:

Bulldozers, farm machinery, forklifts, and other vehicles designed principally for use off public roads

Vehicles maintained for use solely on or next to premises the insured owns or rents

Vehicles that travel on crawler treads

Vehicles, whether they are self-propelled or not, that provide mobility to permanently mounted power cranes, shovels, loaders, diggers, or drills, or road construction or resurfacing equipment such as graders, scrapers, or rollers

Vehicles that are not self-propelled and are maintained primarily to provide mobility to permanently attached equipment such as air compressors, pumps, and generators, or cherry pickers and similar devices used to raise or lower workers

Any vehicle that does not fit the above descriptions and is maintained primarily for purposes other than the transportation of persons or cargo

Insured's Product: Any goods or products, other than real property, that are manufactured, sold, distributed, handled, or disposed of by the insured, others trading under the insured's name, or a person or organization whose business or assets the insured has acquired. This also includes:

- Containers, materials, parts or equipment furnished in connection with the product
- Warranties or representations made at any time with respect to the fitness, quality, durability, or performance of any part of the product
- The providing of or failure to provide warnings or instructions

Insured's Work: Work or operations performed by or on behalf of the insured and any materials, parts, or equipment furnished in connection with the work or operations. This also includes warranties or representations made at any time with respect to the fitness, quality, durability, or performance of the insured's work and the providing of or failure to provide warnings or instructions.

Impaired Property: Tangible property other than the insured's product or work that cannot be used or is less useful because it incorporates the insured's product or work that is known or thought to be defective, deficient, inadequate, or dangerous or the insured failed to fulfill the terms of a contract or agreement.

The property is impaired only if it can be restored to use by repair, replacement, adjustment, or removal of the insured's product or work or by the insured fulfilling the terms of a contract or agreement.

Coverage territory: Usually means the described territory of the United States of America, including its territories or possessions, Puerto Rico, and Canada. It also includes international waters or airspace if the injury or damage occurs in the course of travel or transportation between any places included in the covered territory.

Loading or Unloading: Handling of property:

- after it is accepted for movement into or onto an aircraft, watercraft, or auto
- while it is in or on an aircraft, watercraft, or auto
- while it being moved from an aircraft, watercraft, or auto to the place where it is finally delivered.
- Loading or unloading does not include movement of property by a mechanical device that is not attached to the aircraft, watercraft, or auto, other than a hand truck

Pollutants: Any solid, liquid, gaseous, or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

Employee: Includes a leased worker but not a temporary worker.

Leased worker: Person leased to the named insured by a labor leasing firm under an agreement between the labor leasing firm and the insured to perform duties related the conduct of the insured's business.

Temporary worker: Person furnished to the insured to substitute for a permanent employee on leave, or to meet seasonal or short-term workload conditions. Temporary workers are employees of the supplying company.

Volunteer worker: Person who is not an employee who donates his time and is not paid by the insured or anyone else for work performed. A volunteer acts under the direction of the insured to perform duties related to the insured's business.

B. Automotive: Personal auto and Commercial auto

includes the following coverage options:

1. Liability

a. Bodily Injury

Covers medical expenses for injuries you cause to others in an accident.

- **Example**: You accidentally hit a pedestrian, and they break their arm. Bodily injury liability covers their medical bills.

b. Property Damage

Covers damage you cause to another person's property.

- **Example**: You back into someone's fence, damaging it. Property damage liability covers the repair costs.

d. Split Limits

Specifies separate coverage limits for bodily injury per person, per accident, and property damage per accident.

- **Example**: 25/50/10 means $25,000 for bodily injury per person, $50,000 per accident, and $10,000 for property damage.

e. Combined Single Limit

A single limit that covers both bodily injury and property damage.

- **Example**: A $100,000 combined single limit means up to $100,000 can be used for either bodily injury or property damage, whichever is greater.

2. Medical Payments

Covers medical expenses for you and your passengers, regardless of fault.

- **Example**: You're in a minor accident, and your passenger needs a doctor's visit. Medical payments coverage covers the bill.

3. Physical Damage

Collision: Covers damage to your vehicle from a collision, regardless of fault.

- **Example**: You hit another car in a parking lot. Collision coverage pays for repairs.

Other Than Collision (Comprehensive): Covers damage from non-collision events like theft, fire, or vandalism.

- **Example**: Your car is stolen, and comprehensive coverage pays for the loss.

Specified Perils: Covers specific perils listed in the policy, such as fire, theft, or hail.

- **Example**: Your car is damaged by hail, and specified perils coverage pays for repairs.

4. Uninsured Motorists

Covers damages if you're hit by a driver without insurance.

- **Example**: Another driver hits you and doesn't have insurance. Uninsured motorist coverage pays for your damages.

5. Underinsured Motorists

Covers damages if you're hit by a driver whose insurance isn't enough to cover your costs.

- **Example**: Another driver hits you, and their insurance only covers $10,000, but your damages are $20,000. Underinsured motorist coverage pays the difference.

6. Who is an Insured

Individual Insured: The person named on the policy.

- **Example**: You are the individual insured on your personal auto policy.

Drive Other Car (DOC): Coverage for driving a car not owned by the insured.

- **Example**: You drive a friend's car and have DOC coverage, so you're protected if you have an accident.

7. Types of Auto

a. Owned

A vehicle you own and insure.

- **Example**: Your personal car.

b. Non-Owned

A vehicle you don't own but occasionally drive.

- **Example**: Borrowing a friend's car.

c. Hired

A vehicle you rent or lease.

- **Example**: Renting a car for a vacation.

d. Temporary Substitute

A vehicle temporarily replacing your insured vehicle.

- **Example**: Using a rental car while your car is in the shop.

e. Newly Acquired Autos

Automatically covers new vehicles you acquire.

- **Example**: Buying a new car and it's covered under your existing policy.

f. Transportation Expense and Rental Reimbursement Expense

Covers costs for transportation and rental cars while your vehicle is being repaired.

- **Example**: Your car is in the shop, and rental reimbursement covers the cost of a rental car.

8. Auto Dealers Coverage Form, including Garagekeepers Insurance

Auto Dealers Coverage Form: Provides coverage for auto dealerships, including liability and physical damage.

- **Example**: A dealership is sued for selling a defective car. **Garagekeepers Insurance**: Covers damage to customers' vehicles while in the care of the dealership.
- **Example**: A customer's car is damaged while being serviced at the dealership.

9. Exclusions

Specific situations or conditions not covered by the policy.

- **Example**: Damage from normal wear and tear is typically excluded.

10. Individual Insured and Drive Other Car (DOC)

Individual Insured

Definition: The individual insured is the person or entity explicitly named in the insurance policy. This person has the rights and responsibilities under the policy.

Example: In a personal auto insurance policy, John Doe is listed as the individual insured, meaning he is covered by the policy for any incidents involving his vehicle.

Drive Other Car (DOC)

Definition: Drive Other Car (DOC) coverage extends liability coverage to the named insured when they are driving a vehicle that they do not own and is not listed on their policy.

This is particularly useful for business executives or employees who may need to drive a vehicle that belongs to someone else.

Example: Sarah, a business executive, occasionally drives a rental car for work. With DOC coverage, she is covered for liability while driving the rental car, even though it is not listed on her personal auto policy.

11. Mobile Equipment

Coverage for vehicles that are not primarily used on public roads, such as forklifts or construction vehicles.

- **Example**: A forklift in a warehouse is covered under mobile equipment insurance.

Definitions:

Liability:

Covers bodily injury and property damage caused by the insured while driving.

Physical Damage (Collision and Comprehensive):

Covers damage to the insured's vehicle in the event of a collision or other covered event.

Named Insureds:

Individuals or entities specifically named on the insurance policy.

Garage Coverage Forms:

Provides coverage for businesses that sell, service, or store vehicles.

Lease Gap:

Covers the difference between the actual cash value of a leased vehicle and the remaining balance on the lease in the event of a total loss.

Owned Auto:

Coverage for vehicles owned by the insured.

Nonowned Auto:

Coverage for vehicles not owned by the insured but used for business purposes.

Temporary Substitute Auto:

Coverage for vehicles temporarily used in place of the insured vehicle.

Uninsured/Underinsured:

Coverage for bodily injury or property damage caused by a driver who is uninsured or underinsured.

Objectives: In this section we'll cover casualty policies applicable to personal lines. These provide coverage for claims for which individuals may become legally liable. The following will be covered:

- Personal automobile policy (PAP)
- Personal liability and other personal exposures
- Personal automobile

The Personal Auto Policy (PAP) is a packaged policy that provides property and liability coverage for motor vehicles used by an individual or family members.

The liability coverage provides protection against claims where the insured is held responsible for bodily injury or property damage caused through the use of their automobile.

The property coverage provides protection for damage to the insured's own automobile.

Organization and Coverage

The Personal Auto Policy is made up of a Declarations page and a policy form. The policy form includes four separate coverages, each with its own insuring agreement, conditions, and exclusions. The four coverages are:

Part A –Liability coverage: can be selected on its own.

Part B – Medical payments coverage: can only be selected if Part A is selected.

Part C – Uninsured motorists coverage: can only be selected if Part A is selected and is subject to specific laws. In some states, uninsured motorists coverage is mandatory. In some states the insured can reject coverage in writing.

Part D – coverage for damage to your auto: can be written alone or with liability coverage.

In addition to the coverages provided in the Personal Auto Policy form, there is a Definitions section that provides important definitions applicable to the policy and two additional sections:

Part E – Duties after an accident:

- The insured must notify the insurer as soon as possible after a loss
- The insured must cooperate with the insurer in any investigation
- The insured must notify the police as soon as possible if there is a hit and run or theft is involved
- The insured must take reasonable steps to protect a covered auto from further damage

Part F – General provisions: specifies the obligations of the insured and the insurer, including:

- Specifies the policy period and policy territory, the United States, its territories and possessions, Puerto Rico, and Canada.
- Cancellation and nonrenewal of the policy
- Right to recover payment

Covered autos

Covered autos include:

- A vehicle listed in the Declarations page.
- Eligible vehicles are private passenger vehicles including four wheel cars, SUVs, passenger vehicles, and pickups with a gross weight of less than 10,000 pounds that are not used for business purposes.
- Vehicles used for incidental business purposes can be covered under a Personal Auto Policy. Vehicles used for delivery or commercial purposes must be covered under a Commercial or Business Auto Policy.

- The vehicles must be owned by the insured or leased for a minimum of six months.
- Farming and ranching are not considered businesses.
- A private passenger vehicle (automobile, pickup, or van) the insured acquires during the policy period
- A trailer owned by the named insured
- Any auto or trailer not owned by the named insured but being used as a temporary substitute for a vehicle listed in the Declarations page that is not usable because of breakdown, repair, servicing, loss, or destruction.

Endorsements

The following endorsements are available under the Personal Auto Policy:

Named Non-Owner Coverage for a Named Individual: This endorsement is designed for individuals who do not own a car but drive either a borrowed or a rented car. The policy provides only liability, medical payments, and uninsured motorists coverage. It does not provide coverage for Part D – Damage to your auto.

Joint Ownership Coverage: This endorsement expands the definition of the insured to:

- Two or more individuals who reside in the same household who are not married or
- Non-resident relatives, two or more individuals who are related by blood, marriage, or adoption who do not live in the same household but jointly own the insured vehicle

Miscellaneous Type Vehicles: The Personal Auto Policy, without endorsement, applies to private four-wheel passenger vehicles. This endorsement extends coverage to other types of vehicles, including motor homes, motor cycles, dune buggies, and golf carts.

This endorsement excludes snowmobiles

This endorsement excludes coverage for non-owned vehicles other than temporary substitutes

Towing and Labor Costs: This endorsement provides payment for towing a vehicle to a repair shop or to repair a vehicle at the place of disablement.

Labor costs are only covered if they are performed at the place of disablement. Labor costs at the repair shop after the vehicle has been towed there would not be covered.

It covers owned vehicles covered under the policy and non-owned vehicles in use by the insured.

Extended Non-Owned Coverage – Vehicles furnished or available for regular use: This endorsement removes some of the exclusions and limitations normally imposed in a Personal Auto Policy. This endorsement can provide coverage, with the payment of an additional premium, for:

- Non-owned autos furnished or made available for the insured's regular use
- Excess liability coverage for the individual named on the endorsement and for business use of a commercial-type vehicle that the named insured does not own
- Excess liability coverage for the use of a vehicle as a public or livery conveyance

Optional Limits Transportation Expenses Coverage: This endorsement is used to increase the limits for transportation expenses from $20 per day with a $600 limit.

The increased daily limit and maximum limit are specified

Excess Electronic Equipment: This endorsement provides coverage for electronic equipment permanently installed in the vehicle in a location not used by the manufacturer.

It increases the limit from $1,000 to an amount shown on the endorsement

It covers tapes, records, disks, and other media used with the excess electronic equipment up to $200.

Liability

Under the Part A – Liability Insuring Agreement the insurer will:

- Pay for damages for bodily injury or property damage the insured becomes legally responsible for because of an auto accident
- Settle or defend any claim or suit asking for such damages
- Pay any defense costs in addition to the limits of liability.

Note that the defense costs are included in the insuring agreement and not in supplementary payments. The insurer's duty to settle or defend ends when the limit of liability is reached.

The definition of the Insured includes:

- The named insured and members of the insured's family while using any auto
- This includes the named insured, the insured's spouse, and any family member involved in the ownership, maintenance, or use of any auto or trailer.
- A family member is any person related to the insured by blood, marriage or adoption who is a resident of your household.
- If the insured's 14 year old son had an accident while driving your car, they would be covered even though they did not have your permission (they are a family member) and even though they did not have a license.
- If the insured's 18 year old son had an accident while driving the neighbor's car, they would be covered under the insured's policy even though the insured did not own the car (Part A covers "any auto").
- Anyone using the insured's car with the insured's permission or the reasonable belief that they are entitled to do so
- Other people or organizations to the extent that they share liability with an insured
- Other persons or organizations for their liability arising out of an accident involving any auto or trailer used by the insured or a family member

Part A – Liability includes Supplementary Payments. These are payments made at no additional cost and are paid in addition to the limits of liability. They include:

- **Bail bonds**: Up to $250 for the cost of bail bonds
- **Appeal bonds**: Premiums on appeal bonds or bonds to release attachments
- **Post judgement interest**: Interest that accrues after a judgement in a liability suit the insurer defends on the insured's behalf
- **Loss of earnings**: If the insured is required to attend hearings or trials at the request of the insurer, the insurer will pay up to $200 per day to the insured for loss of earnings
- **Other expenses**: Other reasonable expenses the insured incurs at the request of the insurer

Specific exclusions apply to Part A – Liability coverage:

- Intentional bodily injury or property damage by the insured
- Damage to the insured's own property or property in transit. For example, if you are transporting your own furniture and are involved in an accident, damage to your own property would not be covered.
- Damage to property rented to, used by, or in the care of the insured
- Bodily injury to an employee of the insured. This would be covered under workers' compensation
- Liability arising out of an insured's ownership or operation of a vehicle used as a taxi or livery service. If the vehicle is used as a share-the-cost car pool, coverage does apply.
- Liability arising out of an insured vehicle being used by an auto business. This applies to a business that sells, repairs, services, stores, or parks cars. For example, if a mechanic at a repair shop has an accident while driving your car, this would not be covered.
- Use of a vehicle without the permission of the insured. This does not apply to family members who are included under the definition of "the insured".
- Non-owned vehicles used on a regular basis. For example, if the insured has the use of a company car, the company will have to provide coverage. This would not be covered under the insured's personal auto policy.
- Motorized vehicles with fewer than four wheels or designed for off-road use. This does not apply to non-owned golf carts.
- Vehicles used for commercial purposes. Use of a vehicle, for example, by a sales person would be considered business use and would be covered under the personal auto policy. If a vehicle is used, for example, for delivery of goods, this would be considered commercial use and would not be covered under the personal auto policy.
- Vehicles used in racing or speed contests

The Part A limits of liability specify the limits that will be paid from any one auto accident. The limits are specified as a split limit:

- Per person limit for bodily injury
- Per accident limit for bodily injury

- Per accident limit for property damage

For example, if the limits of liability are 25/50/25, the most the insurer will pay for one auto accident is $25,000 bodily injury per person, $50,000 bodily injury per accident, and $25,000 property damage per accident.

The Part A Financial Responsibility provision addresses the financial responsibility laws. Most states have financial responsibility laws that require a driver to prove that he or she can pay for bodily injury or property damage liability arising out of an auto accident. This is usually provided with an auto insurance policy that meets the state's requirements. The Part A provision states that the insurance company can certify the policy as proof of future financial responsibility.

Part A Out-of-State coverage provision states that the personal auto policy will conform to another state's laws if a covered auto is being driven in another state. If the financial responsibility laws are different in another state, the policy will cover that state's financial responsibility and any other laws. Coverage includes any US territory, Puerto Rico, and Canada. Coverage is not provided in Mexico.

There are instances where the liability for an auto accident is covered by more than one insurance policy.

Where more than one auto liability insurance policy is in place at the time of a loss, each insurer will pay only their share of the loss.

The share of the loss will be in proportion to the limit of liability for each insurer in relation to the total limit of liability.

For example, there are two insurance policies in place. Policy A has a limit of liability for property damage of $50,000. Policy B has a limit of liability for damage of $100,000.

The insured has had an accident and is liable to pay $30,000 in property damages.

The total limit of liability is $50,000 + $100,000 = $150,000. Policy A's share is $50,000 /

$150,000 = one third. Policy B's share is $100,000 / $150,000 = two thirds.

Policy A would pay $10,000 towards the loss and Policy B would pay $20,000 towards the loss.

In the case of a vehicle not owned by the insured, the insured's policy would pay losses on an excess basis.

The owner's policy is the primary insurer

The driver's policy is the excess insurer

For example, you were driving your friend's car and had an accident for which you became liable for bodily injury. The insurer of the owner of the car, your friend, would pay up to its limits of liability. If there were an additional amount to pay, your insurer would pay the excess up to its limits of liability.

Medical Payments

Part B – Medical Payments provides coverage for the named insured, family members, and passengers in the named insured's auto for injuries received in an accident regardless of who is at fault. Medical payments does not provide liability coverage for injuries sustained by passengers in another auto involved in an accident with the insured.

Medical payments coverage pays reasonable expenses for necessary medical expenses or funeral costs within three years of the date of the accident.

The definition of insureds for medical payments includes:

The named insured and any family member

While occupying a motor vehicle designed for use on public roads or a trailer, or

When struck by a vehicle designed for use on public roads or a trailer

Any other person occupying the named insured's covered auto

If the insured struck another car and the occupants of the other car were injured, Part B – Medical payments would not cover the medical expenses or funeral expenses of the occupants of the other car.

Here are a few scenarios where medical payments coverage may help cover expenses:

- Passengers are hurt while you or a family member is driving
- You are injured as a passenger in someone else's car
- You are struck by a car while walking or cycling
- You require dental care after an accident
- You require extended nursing services or hospitalization while rehabilitating
- You require prosthetic limbs

Specific exclusions apply to Part B – Medical payments:

- Injuries sustained while occupying a motorized vehicle with fewer than four wheels
- Injuries sustained while using an auto as a taxi or livery service
- Injuries sustained that would be covered under workers' compensation
- Injuries sustained while occupying an uninsured vehicle owned by the insured or not owned by the insured but provided to the insured for use on a regular basis
- Injuries sustained while occupying an uninsured vehicle owned by a family member or not owned by the family member but provided to the family member for use on a regular basis. This exclusion would not apply to the named insured.
- Injuries sustained while using a vehicle without the permission of the insured. This does not apply to family members who are included under the definition of "the insured".
- Injuries sustained while occupying a vehicle that is being used in the insured's business
- Injuries caused by war or nuclear hazard
- Injuries sustained while using a vehicle as a residence
- Injuries sustained in a vehicle used in racing or speed contests

The Part B limits of liability specify a single amount that will be paid per person injured in an accident. These limits are generally $1,000, $2,000, or $5,000.

In the case where there is more than one insurance policy providing Part B coverage, in the same way that this is covered under Part A:

- Where more than one auto liability insurance policy is in place at the time of a loss, each insurer will pay only their share of the loss.
- The share of the loss will be in proportion to the limit of liability for each insurer in relation to the total limit of liability.

In the case of a vehicle not owned by the insured, the insured's policy would pay losses on an excess basis.

- The owner's policy is the primary insurer
- The driver's policy is the excess insurer

If you don't have a health plan or if your health plan has low limits, you may consider getting medical payments coverage to protect you or family members in case of an auto accident. In some cases, this insurance can help you to recover your health plan's deductible. Part B – Medical payments coverage and your health plan can work together to provide you with maximum coverage in case of an auto accident.

Physical damage (collision and other than collision / comprehensive)

The Part D – Physical Damage Insuring Agreement or coverage for damage to your auto provides optional coverage to cover physical damage to the insured's own car.

Physical damage coverage pays for direct and accidental loss to the named insured's covered auto or any nonowned auto against loss caused by:

- Collision
- Other than collision, also known as comprehensive

This coverage does not include personal property in the vehicle. The following apply to physical damage coverage:

- The insured can select to have collision coverage only, other than collision coverage only, or both.
- The insured's owned vehicles are specified in the Declarations with the insured value of each car
- A premium is charged for the selected coverage
- Deductibles will apply to both collision and other than collision separately

Collision is defined as the impact of an auto covered by the policy with another object or vehicle, or the upset of a vehicle. Examples of collision include:

- One vehicle driving into the back of another vehicle
- Two vehicles hitting each other in an intersection
- Your vehicle hitting the barrier on a motorway
- Your vehicle hitting a rock in the middle of the road

Other than collision damage or comprehensive coverage pays for almost any type of direct, accidental loss to a vehicle that is not specifically excluded. Perils that are specifically mentioned are:

- Missiles or falling objects
- Fire
- Theft or larceny
- Explosion or earthquake
- Windstorm
- Hail, water, or flood
- Malicious mischief and vandalism
- Riot or civil commotion
- Contact with a bird or animal
- Breakage of glass

If glass breakage is the result of a collision, this can be covered under the collision loss at the option of the insured. This allows the insured to pay a single deductible, for collision, for the breakage of glass.

A non-owned auto is any private passenger auto, pickup, truck, trailer, or van not owned by the insured or available for the regular use of the insured or a family member. An example would be a rental car. A temporary substitute is considered a nonowned auto under physical damage coverage.

In addition to collision and other than collision damages, the insured can apply for coverage of transportation expenses incurred by the insured. The following apply to transportation expenses:

- Transportation expenses because of physical damage losses to the insured's covered autos
- Loss of use expenses for which the insured becomes legally responsible because of a loss to a nonowned auto
- Transportation expenses pays up to $20 a day for a maximum of $600
- For losses arising out of total theft of the auto, there is a 48-hour waiting period before transportation expenses will be paid. Coverage continues until the vehicle is returned to use or the insurer pays for its loss
- For other losses, there is a 24-hour waiting period. Coverage is limited to the period reasonably required to repair or replace the vehicle.

Part D excludes the following losses:

- Autos being used for public or livery conveyance
- Due to wear and tear, freezing, mechanical or electrical breakdown, or road damage to tires
- Due to war or nuclear perils

- To electronic equipment that reproduces, receives, or transmits audio, visual, or data signals. This does not apply to equipment that is permanently installed in the auto.
- To tapes, records, disks, and other media used with the electronic equipment mentioned above
- Due to destruction or confiscation by government or civil authorities
- To a camper body, trailer, or motor home that is not listed in the Declarations. This exclusion applies to cooking, dining, plumbing, and refrigeration facilities used with these items. The exclusion does not apply to:
- Trailers and their facilities and equipment not owned by the insured
- Trailers, camper bodies, and their facilities and equipment acquired during the policy period if coverage is requested within 14 days after acquisition
- To a nonowned auto when used by the named insured or family member without reasonable belief that he or she is entitled to do so
- To awnings, cabanas, or equipment designed to create additional living space
- To custom furnishings or equipment in a pickup or van
- To radar or laser detection equipment
- To nonowned autos being used by any person engaged in an auto business
- To nonowned autos being used in any business. This exclusion does not apply to the use of a private passenger auto or trailer by the named insured or family member.
- To any auto being used in a racing or speed contest
- To any auto rented by the named insured or family member if the rental agency is prohibited from recovering from the insured or family member under the provisions of state law or a rental agreement

The following provisions apply to Part D – Physical Damage:

- Physical damage losses are paid based on actual cash value or the amount required to repair or replace the property, whichever is less
- If the insured and the insurer do not agree on the amount to be paid, the loss may be appraised.
- The most the policy will pay for the loss of a nonowned trailer is $1,500
- Coverage for electronic equipment that is permanently installed in an area of the car not normally used by the manufacturer for the equipment is limited to $1.000
- Collision and other than collision coverage is usually written with a deductible that applies separately to each occurrence
- Other sources of recovery (the equivalent of other insurance) states that the insurer will pay only its share of the loss if any other source of recovery, not only insurance, applies to the loss
- No benefit to bailee condition states that a bailee cannot benefit from the insurance policy if a loss occurs to the car while it is in the bailee's possession. Examples of

bailees are owners of repair shops and employees of parking garages.

Uninsured motorists

Part C – Uninsured motorists coverage provides insurance protection to an insured for compensatory damages which the insured is legally entitled to recover from the owner or operator of an uninsured motor vehicle because of bodily injury that results from an automobile accident. Some states provide coverage for property damage caused by an uninsured motorist via an endorsement. Also included are damages due to bodily injury and property damage, if covered, that result from an automobile accident with a hit- and–run vehicle whose owner or operator cannot be identified.

If the other party is not legally liable or not at fault, coverage will not be provided.

An uninsured motor vehicle:

- Has no liability coverage at the time of the accident
- Has liability coverage but it is insufficient to meet the state's financial responsibility requirement
- Is operated by a hit-and-run driver who cannot be identified who strikes an insured or family member, the insured's covered auto, or any auto occupied by the insured or family member

Does not have liability coverage because the insurer is insolvent or denies coverage The definition of an uninsured vehicle does not apply to a vehicle or equipment that is:

- Owned by or available for regular use of the insured or family member
- Owned or operated by a self-insurer except for an insolvent self-insurer
- Owned by a government unit or agency
- Operated on rails or crawler treads
- Designed for use off public roads
- Used as a residence or premises
- The definition of insureds for uninsured motorists insurance includes:
- The named insured and any family member
- Any other person occupying the named insured's covered auto
- Any person entitled to recover damages because of bodily injury caused by an uninsured motorist to the named insured, family members, or passengers in the covered auto. For example, if there are costs involved in the care of children as the result of bodily injury of a parent in the accident, these damages may be included.

Specific exclusions apply to Part C – Uninsured Motorists:

- Bodily injury sustained by an insured while occupying or struck by a vehicle that is owned by the named insured but not insured for uninsured motorists coverage under the policy
- Bodily injury sustained by a family member while occupying or struck by a vehicle owned by the named insured that has primary uninsured motorists coverage under another policy
- For losses settled without the insurer's consent if the settlement prejudices the insurer's right to subrogate against the insured driver
- When the vehicle is being used as a public or livery conveyance
- For losses that occur when the insured is using the vehicle without the reasonable belief that he or she is entitled to. This exclusion does not apply to family members using covered autos owned by the insured.

Specific limits of liability are specified for Part C – Uninsured motorists. These specify the most the insurer will pay for any one accident. The Uninsured motorists limits of liability must meet the minimum limits specified for bodily injury by the state.

The insurer will not:

- Make duplicate payments for losses paid under more than one part of the policy
- Make duplicate payments for losses paid by or on behalf of the person who was responsible for the accident
- Pay any part of a loss that would be covered under a workers' compensation or disability benefits law

Where other insurance is involved:

Where more than one policy is in place that provides uninsured motorists coverage, the total amount the insured may collect cannot exceed the highest limit applicable to any one vehicle. For example, if the limits of liability on one policy are 25/50 and the limits of liability on the second policy are 100/300, the most the insurer will pay for any accident is 100/300.

If the loss is the result of the insured occupying a non-owned vehicle, the policy covering the non- owned vehicle would provide primary coverage and the insured's policy would provide excess coverage.

If more than one policy applies, the insurer will pay only its share of the loss which is in proportion to its limits of liability in relation to the total amount of coverage. This is similar to the scenario described under Part A – Liability.

Part C includes specific provisions regarding arbitration when the insured and the insurer do not agree whether the insured is entitled to uninsured motorists coverages or not or if there is a disagreement about the amount of the damages.

During the 2008 Session of the Georgia General Assembly, a law was passed that requires an automobile insurance carrier to provide revised Uninsured Motorist coverage unless the insured rejects this coverage in writing. This is known as Uninsured Motorist Coverage – Added on to At-Fault Liability Limits or "New Uninsured Motorist Coverage".

New Uninsured Motorist Coverage provides additional protection at a higher premium than the standard Uninsured Motorist coverage. If an insured is injured or has property damage caused by an uninsured or underinsured motorist, the New Uninsured Motorist Coverage will pay for your damages in addition to the at-fault driver's liability coverage limit up to your New Uninsured Motorist Coverage limit.

Underinsured motorists

Underinsured motorists coverage provides coverage for the insured where the liability insurance paid for bodily injury in an auto accident where the driver is at fault is insufficient to cover the amount of the loss the insured has incurred.

For example:

The driver of a vehicle carries the minimum amount of liability coverage required by the state for bodily injury of 25/50.

This driver is responsible for an accident in which the insured suffers bodily injury and the driver is found to be legally liable to pay damages to the insured.

The insured's loss is $35,000.

The driver's insurance will pay $25,000 to the insured towards his loss.

The underinsured motorists' coverage on the insured's policy will pay the difference between what the driver's insurance pays and the amount of the loss incurred by the insured, up to the limits of liability on the insured's policy.

If the insured's limits of liability for Underinsured motorists coverage is also 25/50, their insurance will pay the additional $10,000 incurred by the insured.

The at-fault driver's insurance is the primary insurer. The insured's insurer covers the excess. There is an additional premium required for Underinsured motorists coverage.

Who is an insured

- Under the Personal Auto Policy the definition of the Insured includes:
- The named insured and members of the insured's family while using any auto
- This includes the named insured, the insured's spouse, and any family member involved in the ownership, maintenance, or use of any auto or trailer
- A family member is any person related to the insured by blood, marriage or adoption who is a resident of your household.
- If the insured's 14 year old son had an accident while driving your car, they would be covered even though they did not have your permission (they are a family member) and even though they did not have a license.
- If the insured's 18 year old son had an accident while driving the neighbor's car, they would be covered under the insured's policy even though the insured did not own the car (Part A covers "any auto")
- Anyone using the insured's car with the insured's permission or the reasonable belief that they are entitled to do so
- Other people or organizations to the extent that they share liability with an insured

- Other persons or organizations for their liability arising out of an accident involving any auto or trailer used by the insured or a family member

No Fault Insurance

Liability insurance pays only for damages for which the insured is found to be legally liable. This requires lengthy and costly lawsuits. To address this issue, some states have adopted no-fault laws whereby an insured driver is reimbursed by his own insurer for medical expenses and loss of wages regardless of who was at fault in an auto accident. Subrogation from the other company is not allowed.

There is no payment for pain and suffering under pure no-fault law.

Assigned Risk Plans

Assigned Risk Plans or Automobile Insurance Plans are plans to provide auto insurance to drivers who are not able to obtain this insurance due to bad driving records. These drivers need to be covered to meet their financial responsibilities in case of an accident.

Insurance companies licensed in a state agree to share these poor risks among themselves. The risks are randomly assigned to the participating insurers based on the relative size of their business in the state.

Drivers are required to have the minimum amount required by law for bodily injury and property damage but may also get coverage for medical payments and physical damage.

Commercial or Business Auto Insurance

Objectives: In this section we'll cover the various Commercial or Business Auto coverage forms. The following are covered:

Structure and sections of the Business Auto Coverage form

- The Business Auto Physical Damage Coverage form
- Garage Coverage form
- Garagekeepers Coverage form
- Truckers Coverage form
- Motor Carrier Coverage form

Endorsements

Commercial Auto Coverage provides insurance for private passenger and commercial auto exposures of businesses. The Commercial Auto policy can be included in a Commercial Package Policy or can be written as a monoline policy.

Structure of the Business Auto coverage form

The Commercial Auto coverage part must include the following elements:

- Common policy declarations
- Common policy conditions
- One of the following forms:
- Business Auto Coverage Form

- Business Auto Physical Damage Coverage Form
- Garage Coverage Form
- Truckers Coverage Form
- Motor Carrier Coverage Form
- Declarations for the coverage form selected

The Business Auto Coverage form provides coverage for private passenger and commercial auto exposures for all businesses other than garages, truckers, and motor carriers. Specialized forms are used to cover these businesses.

The Business Auto Coverage form includes liability coverage and physical damage coverage (comprehensive or specified causes of loss and collision). Uninsured motorists, medical payments, and underinsured motorists coverage can be added by endorsement.

Business Auto Coverage form sections

The Business Auto Coverage form is divided into five sections:

Section I: Covered autos

Section II: Liability coverage

Section III: Physical damage coverage

Section IV: Conditions

Section V: Definitions

Section I: Covered autos

The insured can select what autos are covered for each of the coverages selected. These are specified in the Declarations. The Business Auto Coverage form uses a numerical symbol system to describe the categories of covered autos. These are as follows:

Symbol	Covered Auto	Description
1	Any auto	This designates coverage for any auto the insured will use during the policy period, including autos the insured owns, leases, hires, rents, or borrows. This designates liability coverage only.
2	Owned autos only	This designates coverage for any auto the insured owns. This designates other coverages besides liability coverage.

3	Owned private passenger autos only	This designates coverage for any private passenger auto the insured owns. This designates any coverages provided by the business auto coverage form.
4	Owned autos other than private passenger autos only	This designates coverage for any vehicles the insured owns other than private passenger autos, such as trucks, trailers, buses, and motorcycles. This designates any coverages provided by the business auto coverage form. This can be used, for example, if the insured wants different coverage for these types of vehicles than they want for their private passenger autos.

5	Owned autos subject to no-fault law	This designates coverage for owned autos required to have no-fault benefits in a particular state.
6	Owned autos subject to compulsory uninsured motorists law	This designates coverage for owned autos required to have uninsured motorists coverage in a particular state.
7	Specifically described autos	This designates that coverage is provided only to autos specifically listed in the business auto coverage form declarations.
8	Hired autos only	This designates coverage for autos the insured hires, leases, rents, or borrows. It does not cover autos rented or borrowed from employees or members of their households. This designates liability and / or physical damage only

9	Nonowned autos only	This designates coverage only for autos the insured does not own, hire, lease, rent, or borrow. This covers autos owned by employees or members of their households and used either in the business or for their personal use. This designates liability coverage only
19	Mobile equipment subject to motor vehicle laws only	This designates coverage for mobile equipment that is subject to compulsory or financial responsibility laws or any other motor vehicle laws. Mobile equipment is specifically excluded under the definition of "auto" in a business auto policy, so this is used when mobile equipment has to be included to meet the above-mentioned requirements.

The broadest coverage is provided by selecting Symbol 1. This covers any auto the insured uses, whether owned or not.

If the insured has liability coverage, the following are also covered for liability:

A temporary substitute

Trailers with a load capacity of 2,000 pounds or less

Mobile equipment while it is being towed or carried by a covered auto

Types of auto

Owned

Owned autos are considered privately owned by the business for conducting business. Vehicle types include:

- Passenger autos, vans, and buses
- Trucks, both light and heavy

Non-owned

A non-owned auto is a vehicle that is not owned by, registered, or contracted in the name of the insured. Non-owned auto coverage provides liability protection when an employee has to drive their own personally owned vehicle for business purposes.

Hired

Hired auto coverage provides liability coverage when the insured is driving a hired, leased, rented, or borrowed vehicle.

Temporary Substitute

The insurer will cover automobiles that are temporarily substituted for an auto that is described in the declarations. For example, if a service shop lends the insured a vehicle while an owned auto is in for repair or service, this would be considered a temporary substitute.

Section II: Liability coverage

The Business Auto Liability coverage agrees to pay damages for bodily injury or property damage the insured is legally liable for caused by an accident resulting from the ownership, maintenance, or use of a covered auto. The insurer will also pay defense costs and supplementary payments.

In addition to this, the insurer also agrees to pay sums the insured is legally liable for for covered pollution costs or expenses to which the policy applies. The pollution must be caused by an accident and result from the ownership, maintenance, or use of a covered auto. Pollution costs will only be paid if there are bodily injury or property damage damages associated with the same accident.

Who is included as an insured

In addition to the named insured, other drivers using a covered vehicle with permission have liability coverage. The policy also covers those who become liable for the conduct of an insured.

Specifically excluded are:

- The owner of an auto hired or borrowed from an employee or family member
- A person working in an auto-related business
- People besides employees or lessees while moving property to or from a covered auto
- The owner of a hired or borrowed auto

Supplementary payments

Liability coverage will cover the following supplementary payments:

- Claims expenses the insurer incurs
- Cost of bail bonds up to $2,000 for violations because of a covered accident
- Cost of bonds to release attachments within the limit of insurance
- Expenses the insured incurs at the insurer’s request
- The insured’s loss of earnings up to $250 per day because of time off work
- Costs the insured is required to pay because of a lawsuit
- Interest that accrues after a judgement and before it is paid

Losses covered under the supplementary payments do not reduce the policy’s limits of liability.

The liability coverage provides out of state coverage to meet other states' financial responsibility requirements and other state laws when a covered auto is being driven in that state. The out of state coverage extensions modify the policy's liability coverage to meet other states' financial responsibility requirements and other state laws concerning out of state drivers when the covered auto is being driven in that other state. For example, if the required limit of liability in another state is higher than the insured's local state requirement and an accident occurs where the insured becomes legally liable in that state, the insurer will pay the higher.

The form provides worldwide liability coverage for private passenger autos the insured hires, rents, or borrows without a driver for 30 days or less. The insured's liability must be established in a settlement agreed to by the insurer or in a suit filed in the United States or its territories and possessions.

Section III: Physical Damage coverage

Physical damage coverage provides other than collision, comprehensive or specified causes of loss, and collision insurance, similar to that covered in the Personal Auto Policy.

Comprehensive coverage covers losses as the result of all perils other than collision and specified exclusions.

Other than collision for specified causes of loss covers losses due a limited list of perils – fire, lightning, explosion, theft, windstorm, hail, earthquake, flood, vandalism, malicious mischief, and sinking, burning, collision, or derailment of a conveyance transporting the covered auto.

Collision covers collision with another object or overturn of the covered auto.

The insured can select physical damage for the different categories of autos separately by specifying the coverage for each of the symbols selected, they can select other than collision or collision separately, and they can select individual autos to be covered for physical damage.

Deductibles are specified separately for comprehensive, other than collision specified causes of loss, and collision coverage. The standard deductible is $500 per covered auto per loss.

If the policy covers comprehensive losses, losses due to glass breakage, hitting a bird or animal, and falling objects or missiles are treated as comprehensive losses. Glass breakage can also be covered by collision insurance, so the insured can elect how to have this covered to avoid duplicate deductible payments.

In addition to the payment of the losses described above, the insurer will cover the following:

Towing and labor costs incurred when a covered private passenger vehicle is disabled

Transportation expenses. This includes covering transportation expenses as a result of the theft of a covered vehicle. This coverage begins 48 hours after the theft and ends when the vehicle is returned or the insurer pays for the loss of the vehicle. Coverage is limited to a maximum of $20 a day or a total of $600.

Loss of use expenses to rented autos for which the insured is legally liable under a contract of agreement. Coverage is limited to maximum of $20 a day or a total of $600.

The following exclusions apply:

- Sound reproducing and receiving equipment, tapes and records
- Wear and tear, freezing, mechanical or electrical breakdown, or road damage to tires
- War and nuclear events

- Covered autos while being used for organized or professional racing, demolition, or stunting activities
- Diminution in value

Section IV: Conditions

Specific conditions apply to the Business Auto coverage:

Settling Physical Damage claims: The insurer can settle a claim in one of three ways:

Pay for, repair, or replace the damaged or stolen property

Return the stolen property to the insured at the insurer's expense and pay for damages due to the theft

Take the damaged or stolen property at an agreed or appraised value

Other insurance:

The Business Auto Coverage form provides primary coverage for autos owned by the insured and, for liability losses, covered trailers connected to covered autos owned by the insured.

Coverage is excess for losses involving autos not owned by the insured or trailers connected to nonowned vehicles.

If the Business Auto Coverage form and the other insurance cover on the same basis, whether it is primary or excess coverage, the Business Auto Coverage form will pay only its share of the loss based on the proportion of its coverage.

Two or more policies issued by the same insurer: If more than one policy or coverage form issued by the same insurer applies to a loss, the most the insured will receive is the limit of liability on the policy with the highest limit.

Section V: Definitions

The following definitions are of interest:

Mobile Equipment: Any of the following types of land vehicles, including any attached machinery or equipment:

- Bulldozers, farm machinery, forklifts, and other vehicles designed primarily for use off public roads
- Vehicles maintained for use solely on or next to premises owned or rented by the named insured
- Vehicles that travel on crawler treads
- Vehicles, whether self-propelled or not, that are maintained primarily to provide mobility to permanently mounted power cranes, shovels, loaders, diggers, drills and road construction or resurfacing equipment such as graders, scrapers, or rollers.

Pollutant: Any solid, liquid, gaseous, or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste.

Business Auto Physical Damage Coverage Form

The Business Auto Physical Damage Coverage Form covers the insured's owned or hired autos for physical damage only. This is similar to Section III of the Business Auto Coverage Form but covers only the following:

- Owned autos only
- Owned private passengers only
- Owned autos other than private passenger autos only
- Specifically described autos
- Hired autos only

Garage Coverage Form, including Garagekeepers insurance

The Garage Coverage form is designed to meet the needs of insureds who are in the automobile business. This includes automobile, motorcycle, and truck dealerships, repair shops, service stations, and parking lots.

The Garage Coverage form can provide the following coverages:

- Liability coverage
- Garagekeepers coverage
- Physical damage coverage

The Garage Coverage form can be included in a Commercial Package Policy or in a separate policy.

The Garage Coverage form provides coverage for automobile liability, physical damage, and general liability, including premises and operations, completed operations, and product liability for eligible businesses.

Covered autos

The Garage Coverage form includes the same covered autos as those in the Business Auto form but with different numerical symbols, 21 – 29. In addition to this, there are two additional categories:

Symbol 30: Customers' autos left with the insured for service, repair, storage, or safekeeping

Symbol 31: Physical damage coverage only for the dealer's autos, including owned autos, autos for sale, and autos on consignment

Liability coverage

- The Liability coverage under the Garage Coverage form covers auto and business liability arising out of:

- The ownership, maintenance, or use of covered autos (garage operations – covered autos). This insurance is similar to the business auto coverage with one exception.
- It does not cover garage customers if they have their own liability coverage.
- If customers do not have their own liability insurance, the garage form will cover them but only up to the minimum limits of financial responsibility. The insured can add coverage for customers up to the full limits of liability of the policy.

Examples of what this covers include an employee of a repair shop taking a customer's car on a test drive, or the owner of the business driving a company-owned vehicle, a customer that is injured on the premises, or product liability related to a bad or incomplete repair.

Garage operations (garage operations – other than covered autos). The insured covered includes the named insured, the insured's employees, and the business's directors and shareholders while they are acting within their scope of duties.

Examples of what this covers include a customer that is injured on the premises, or product liability related to a bad or incomplete repair.

The Garage Coverage liability has similar exclusions to the business auto coverage form.

It specifically excludes:

- damage to the property of others in the insured's care, custody, or control
- property damage to the insured's own products or work
- product or work recalls

Garagekeepers coverage

The Garagekeepers coverage under the Garage Coverage form covers the insured's liability for damage to the customer's property that the insured has for servicing, repair, parking, or storing.

The coverage form includes collision and comprehensive coverage for customer vehicles in the care, custody, or control of the insured.

The insured can also purchase direct damage Garagekeepers insurance which pays for the physical damage to a customer's property in the insured's care, whether or not the insured is liable.

This direct damage can be provided on a primary or excess basis and the causes of loss can include comprehensive or specified causes of loss and collision.

Coverage is usually provided on a blanket basis.

Losses are usually paid based on actual cash value and a deductible generally applies.

There is no coverage for theft of a car by an employee or for loss of CD players, CDs, and so on.

Physical damage

The physical damage coverage under the Garage Coverage form covers physical damage to vehicles they own themselves.

Coverage can be provided for collision and comprehensive.

Coverage is usually provided on a blanket basis.

Collision damage is usually excluded for autos being driven or transported from the point of purchase or distribution to the point of destination if the distance is more than 50 miles.

Truckers Coverage Form

The Truckers Coverage Form is used to provide coverage for businesses that are paid to haul the goods of others.

The Truckers coverage form provides for three coverages:

1. Liability
2. Trailer interchange
3. Physical damage

Covered autos are specified using a similar numerical symbol system to that used by the Business Auto Coverage form. The symbols used are different and there is no coverage for owned private passenger autos.

The trailer interchange coverage provides insurance when a trucker needs to hire or borrow a trailer from another trucking business for use in their business. The trailer coverage insurance covers damage to a specific trailer under the policy of the trucker in whose possession the trailer is at the time of loss. For coverage to apply, the trucker must be liable under a written interchange agreement and the damage must be caused by a covered peril

There are two symbols that are unique to the Truckers Coverage form and apply to the trailer interchange coverage:

Symbol 48: Trailers borrowed or leased by the named insured for which liability for loss has been assumed under a written trailer exchange agreement. This coverage applies to comprehensive, specified causes of loss, and collision coverages for trailer interchange coverage only.

Symbol 49: Trailers owned or hired by the named insured while the trailers are in someone else's possession under a written trailer interchange agreement.

The liability and physical damage coverage is similar to that in the Business Auto Coverage form.

Motor Carrier Coverage Form

A trucker is a person hired to haul the goods of others. A motor carrier is anyone who transports property by auto in a commercial enterprise, whether hired to do this or not. A trucker could use the Motor Carrier Coverage form or the Truckers Coverage form.

The Motor Carriers Coverage form is almost identical to the Truckers Coverage form. The main difference is that it will cover private passenger autos.

The Motor Carrier Act of 1980 requires that trucking companies certify that they are able to meet financial obligations if they become liable for bodily injury or property damage as a result of their trucking operations. This is typically covered by obtaining truckers coverage to cover the commercial auto liability and commercial inland marine motor truck cargo insurance to cover liability related to the cargo being hauled.

The following are the limits of liability required by the Motor Carrier Act for vehicles with a gross weight of 10,000 pounds or more:

- $750,000 for interstate transportation of non-hazardous material

- $5,000,000 for either interstate or intrastate transportation of large quantities of hazardous material, such as compressed gas, explosives, radioactive material, or oil
- $1,000,000 for either interstate or intrastate transportation of oil or other hazardous wastes.
- Vehicles with a gross weight of less than 10,000 pounds must comply with the financial responsibility limit of $5,000,000 if the vehicle transports explosives, any quantity of poison gas, or large quantities of radioactive materials.

If this insurance is used to provide proof of financial responsibility, the MCS-90 Endorsement must be included with the policy. This endorsement provides public liability coverage for bodily injury, property damage, and environmental restoration.

Endorsements

The following endorsements are available under Commercial Auto coverage forms:

- **Drive Other Car Coverage Endorsement**: This endorsement extends the definition of covered autos to include autos the named insured does not own, hire, or borrow while being used by the person named in the endorsement. This does not cover autos the person owns or those owned by their family members. This would be used, for example, if a business owner has no personal auto protection and uses a non-owned or hired auto for personal use.
- **Individual Named Insured**: This endorsement provides personal auto coverage for immediate family members of the named insured. Without this endorsement, family members would be covered under a commercial auto policy for commercial use but not for personal use.
- **Employees as Additional Insureds**: This endorsement provides coverage for employees using their own vehicles for business use. It will also cover an employee using a family member's auto while on business.
- **Mobile Equipment Endorsement**: This endorsement allows mobile equipment, normally excluded, to be covered as a covered auto. Remember, if mobile equipment is being transported by a covered auto, it is covered under the Business Auto Coverage form.
- **Uninsured, underinsured, and medical payment coverage can be added as an endorsement.**

C. Workers Compensation insurance, Employers Liability insurance, and Related issues

1. Standard Policy Concepts

Overview: Standard policy concepts refer to the basic principles and definitions that underpin insurance policies, such as who qualifies as an employee or employer, and what constitutes compensation2.

a. Who is an Employee/Employer

An employee is someone who performs work for an employer in exchange for compensation. An employer is the person or entity that hires and pays the employee1.

b. Compensation

This refers to the payment or benefits provided to an employee for their work, which can include wages, salaries, bonuses, and other forms of remuneration.

2. Work-related vs. Non-work-related

Overview: This concept distinguishes between injuries or illnesses that occur as a result of work activities (work-related) and those that happen outside of work (non-work-related).

Example:

- **Work-related**: An employee slips and falls while working on a construction site, resulting in a broken leg.
- **Non-work-related**: An employee injures their ankle while playing soccer on the weekend.

3. Other States' Insurance

Overview: This refers to the differences in insurance requirements and coverage across various states, as insurance laws can vary significantly from one state to another.

Example:

- **State A**: Requires all businesses with more than one employee to carry workers' compensation insurance.
- **State B**: Allows businesses with fewer than five employees to opt-out of workers' compensation insurance.

4. Employers Liability

Overview: Employers liability insurance provides coverage for legal fees, settlements, and judgments when employees pursue monetary damages beyond what workers' compensation insurance covers.

Example:

- An employee sues their employer, claiming that negligence led to a severe injury that wasn't fully covered by workers' compensation. Employers liability insurance would cover the legal costs and any settlements or judgments.

5. Exclusive Remedy

Overview: This principle states that workers' compensation is the sole remedy for employees injured on the job, preventing them from suing their employer for damages.

Example:

- An employee accepts workers' compensation benefits for a work-related injury and, as a result, waives the right to sue the employer for additional damages.

6. Premium Determination

Overview: Premium determination involves calculating the cost of an insurance policy based on various factors such as the type of business, number of employees, and historical claims data.

Example:

- A small retail business with 10 employees and a low history of workplace injuries might pay a lower premium for workers' compensation insurance compared to a construction company with 50 employees and a higher risk of injuries.

Workers' Compensation Insurance, Employers Liability Insurance, and Related Issues

Objectives: In this section we'll cover workers compensation. The following are covered:

- Workers' compensation laws
- Workers' compensation benefits
- Covered occupations
- Funding
- The workers' compensation and employer liability policy
- Work-related and non-work-related
- Other states' insurance

Workers Compensation/Employer's Liability

insurance includes:

Policy Concepts:

Provides coverage for employees who are injured or become ill on the job.

Rating Plans:

Methods used to determine premiums based on factors such as type of work and claims history.

NCCI Experience Modifications:

Adjustments to premiums based on a business's claims history and safety record.

Workers' compensation laws

Workers' compensation is a benefits program created by state law that gives employees the right to claim medical, rehabilitation, income, death and other benefits from an employer due to injury, illness or death resulting from a work-related claim covered by the law.

Payment of claims under workers' compensation are made regardless of fault or negligence by the employer, the employee, or a fellow employee.

In some states, Georgia included, workers' compensation insurance is compulsory. An employer is required to provide workers' compensation insurance if they regularly employ three (3) or more individuals, part-time or full-time.

In some states the provision of workers' compensation insurance is elective. In this case, the employer opts out of offering workers' compensation but at great risk as they are then open to be sued in case of an employee's injury, disease, or death.

The premiums for workers' compensation insurance depend on the type of occupation. The more hazardous the occupation, the higher the rates. The employer is responsible for the payment of premiums.

The benefits covered under workers' compensation are the only benefits available to an employee against employers for injuries covered under the law. The employee cannot sue the employer or receive any other compensation for the injuries sustained under the workers' compensation law. This is known as exclusive remedy.

Workers' compensation benefits

There are four categories of benefits payable under workers' compensation:

- Disability income
- Medical
- Death / survivor
- Rehabilitation

Disability income benefits

Disability income benefits pay income benefits if the insured has a loss of income due to a disability caused by a work-related injury covered under workers' compensation.

There is a limit to the disability income benefit. Disability income is not taxable.

There are several different categorizations of disability:

Permanent disability: The disability will affect the person for the rest of his or her life.

Temporary disability: The disability is temporary and the individual will recover.

Temporary total disability: The individual is totally disabled and unable to do any work but will recover and be able to go back to the work. The benefit payable is two thirds of the average weekly wage. If the injury is catastrophic, there is no limit on how long the individual can receive benefits. If the injury is non-catastrophic, the benefits are limited to 400 weeks.

Temporary partial disability: The individual is partially disabled and able to perform a job but at a lower income. The benefit payable is the difference between two thirds of the pre-injury wages and the post-injury wages. That is, the maximum income and benefit to the individual is two thirds of their weekly wages. The benefits are limited to 350 weeks.

Permanent total disability: The individual is totally and permanently disabled and will not be able to return to work. The benefits payable are the same as for temporary total disability, that is, two thirds of the individual's average weekly wage, but payable for life.

Permanent partial disability: The individual is partially and permanently disabled. They will not recover from the injury or disease but may be able to do some type of work, even if it is not the type of work they were able to do prior to the disability. The benefit is determined by formula that includes several factors such as percentage of impairment and type of injury.

Medical benefits

Medical benefits pay 100% for the cost of medical services related to the injury. There is no limit on the medical benefit or the period of time medical benefits are provided. Medical benefits include mileage to and from the doctor and prescription drugs.

Death / Survivor benefits

Death / Survivor benefits pay the spouse, children, or other dependents of an employee who dies of a work-related injury or illness covered under workers' compensation.

Dependents will receive two-thirds of the employer's average weekly wage or a maximum of $525.00 per week.

A widowed spouse with no children is limited to a total amount of $150,000.00 unless he or she remarries or cohabitates in a relationship, in which case benefits will end.

In addition to this, there is a one-time benefit to cover funeral and benefit expenses.

Rehabilitation benefits

Rehabilitation benefits pay the cost of physical or psychological therapy and reasonable costs to train the injured employee to do another job.

Covered occupations

There are certain categories of workers for whom employers are exempt from providing workers' compensation insurance:

- Certain seasonal farm and agricultural workers
- Domestic employees
- Independent contractors
- Casual laborers

There are some occupations that cannot meet the underwriting criteria. These occupations can obtain coverage through a state-established fund, the Assigned Risk Pool, a Residual Market Plan, which is funded by all workers' compensation companies.

Coverage for some occupations and benefits can only be provided by endorsement to the workers' compensation policy.

The federal Longshore and Harbor Workers Compensation Act provides benefits to maritime employees injured while working on navigable waters or shore-site areas of the United States and territories and takes precedence over the state laws. This coverage is provided by an endorsement to the workers' compensation policy.

Some exempt employees, such as domestic and farm workers, can be added to workers' compensation insurance with the Voluntary compensation endorsement.

There are some other categories of employees that are covered by federal, rather than state, workers' compensation laws.

The Federal Employers Liability Act (FELA) allows interstate railroad workers to sue their employers for negligence.

The Jones Act allows members of ships' crews to sue either the employer or shipowner for work- related injuries caused by negligence.

Funding

Workers' compensation insurance can be provided by private insurers or by the state. State insurance can be:

Monopolistic: Workers' compensation insurance is available only through the state fund

Competitive: Workers' compensation insurance is available either through private insurers or through a state fund. They compete with each other in the state.

In Georgia, workers' compensation insurance is typically provided by private insurers. There is no state fund.

Some employers, when state-approved, elect to self-insure their workers' compensation insurance. This may be for a single employer or employers may form a group in order to self-insure. An employer or group of employers who elect to self-insure will have to prove that they have the funds to cover any claims. The state will issue a Certificate of Self Insurance and the self-insurer may have to purchase a surety bond. Some self-insurers will purchase excess insurance or reinsurance. In addition to this, self- insurers will be required to handle the payment of benefits, claim expenses, medical and legal services.

The Secondary Injury Fund was created in 1923 to make benefit payments to totally and permanently disabled workers where the cause of the disability was subsequent to a prior disability rendering the worker permanently and partially disabled. The concept behind the fund is to encourage employers to hire disabled workers by limiting, in the case of further injury, their liability for compensation payments to amounts applicable to the latest injury. The fund assumes liability for any remaining continuing benefits.

Standard policy concepts

The standard workers' compensation and employer liability policy is based on the National Council on Compensation Insurance (NCCI) policy. This comprises an information page, similar to the Declarations page in other insurance policies and the following sections:

General Section: Contains definitions and conditions that apply to the policy

Part One – Workers' Compensation: Provides benefits as described above required by state law for the state or states covered according to the Information page.

Part Two – Employers Liability: Provides liability insurance for an employer for a work-related injury, disease, or death not covered by workers' compensation insurance.

Examples include employees exempt from workers' compensation insurance or the spouse of an injured or diseased employee who sues the employer for loss of consortium.

Limits of liability are specified Per Employee, Per Accident, and Per Policy Period. There is a minimum policy limit of $100,000 per accident.

In addition to the limits of liability, supplementary payments are covered such as defense costs, expenses incurred by the insured at the request of the insurer, for example, related to the investigation of the claim, and appeal bonds.

Part Three – Other States Insurance: States for which the insured has workers' compensation coverage are included in the Information page. This section allows the insured to specify that they may require coverage in additional states, not specified, in the future. This could, for example, cover employees travelling through or working temporarily in another state. The insured will be required to notify the insurer as soon as work begins in a new state not yet listed in the Information page.

Part Four – Your Duties if Injury Occurs: Covers the procedures to be followed in the case of an employee's injury for which there may be coverage. The insured is required to provide medical services to the injured employee, report the injury to the insurer, and cooperate with the insurer in the investigation and settlement of the claim.

Part Five – Premium: Provides details on how the premiums are calculated. The employer is required to maintain records and the insurer can audit the records.

Part Six – Conditions: Covers the conditions that apply to the policy such as cancellation, subrogation, and the rights of the insurer to inspect the insured's workplace.

Work-related vs. non-work-related

Any injury, illness or death arising out of and in the course of employment is covered by workers' compensation insurance. This means if employees are injured while performing their assigned duties during assigned work hours, workers' compensation will cover the claim. Injuries are covered on the employer's premises and off-premises if the employee is performing assigned duties off-premises.

Injuries are not covered if they are sustained:

while performing unassigned duties

during lunch or break times

during their commute to and from work

Other states' insurance

States for which the insured has workers' compensation coverage are included in the Information page. This section allows the insured to specify that they may require coverage in additional states, not specified, in the future. This could, for example, cover employees travelling through or working temporarily in another state. The insured will be required to notify the insurer as soon as work begins in a new state not yet listed in the Information page.

Monopolistic states are excluded.

D. Crime

1. Employee Dishonesty

Overview: Employee dishonesty coverage protects businesses from financial losses due to fraudulent acts committed by employees, such as theft of money, securities, or property.

Example: An employee embezzles funds from the company's accounts. Employee dishonesty coverage reimburses the business for the stolen funds.

2. Theft

Overview: Theft coverage protects businesses against losses resulting from the unlawful taking of money, securities, or property.

Example: Someone breaks into a retail store and steals merchandise. Theft coverage compensates the store for the value of the stolen goods.

3. Robbery

Overview: Robbery coverage protects against losses resulting from the use of force or threat of force to steal money or property from a person.

Example: An armed robber holds up a convenience store and steals cash from the register. Robbery coverage compensates the store for the stolen money.

4. Burglary

Overview: Burglary coverage protects against losses resulting from unlawful entry into a secured premises to commit theft.

Example: A burglar breaks into an office building overnight and steals computers and other equipment. Burglary coverage compensates the business for the stolen items.

5. Forgery and Alteration

Overview: Forgery and alteration coverage protects businesses against losses resulting from the forgery or alteration of checks, drafts, or other financial instruments.

Example: An employee forges signatures on company checks to steal money. Forgery and alteration coverage reimburses the business for the stolen funds.

6. Mysterious Disappearance

Overview: Mysterious disappearance coverage protects against losses when property disappears without any known cause or evidence of theft.

Example: An expensive piece of equipment goes missing from a company's warehouse, but there is no evidence of theft or burglary. Mysterious disappearance coverage compensates the business for the lost item.

Crime coverage is an essential component of insurance policies for businesses, providing protection against various types of criminal activities. Here are some key areas covered under crime coverage:

Employee Dishonesty: This coverage protects businesses from losses caused by dishonest employees engaging in theft or fraud. For example, if an employee steals money from the company's cash register or embezzles funds from the company's accounts, the business can make a claim under this coverage to recover the losses.

Theft, Disappearance, and Destruction: This coverage provides protection against property being stolen, lost, or damaged. For instance, if valuable equipment is stolen from the business premises or inventory goes missing under suspicious circumstances, the business can file a claim to recoup the financial losses.

Robbery and Safe Burglary: This coverage is designed to protect against losses incurred due to theft involving force or breaking into a safe or vault. If armed robbers break into the business premises and steal cash from the safe, the business can utilize this coverage to recover the stolen amount.

Premises Burglary: This coverage specifically applies to losses due to theft on the insured's premises. For example, if burglars break into the warehouse and steal goods stored there, the business can seek compensation under this coverage for the stolen items.

Custodian: This coverage safeguards against losses due to theft committed by a custodian on the insured's premises. If a custodian responsible for handling valuable assets steals them, the business can make a claim under this coverage to mitigate the financial impact.

Messenger: This coverage protects against losses resulting from theft committed by a messenger on the insured's premises. For instance, if a messenger entrusted with delivering cash to a bank absconds with the money, the business can seek reimbursement under this coverage.

Guard or Watchperson: This coverage provides protection against losses due to theft on the insured's premises, where a guard or watchperson is involved in the criminal activity. If a security guard colludes with thieves to steal valuable property from the business premises, the business can invoke this coverage to recover the losses.

Fidelity Bonds: Fidelity bonds offer coverage against losses arising from employee dishonesty, including theft, fraud, and embezzlement. Businesses can purchase fidelity bonds to protect themselves from financial harm caused by unscrupulous employees engaging in criminal activities.

In conclusion, crime coverage is crucial for businesses to mitigate the risks associated with various criminal activities and safeguard their assets against potential losses. By understanding the different types of coverage available under crime insurance, businesses can effectively protect themselves against financial harm resulting from employee dishonesty and theft.

Crime

Objectives: In this section we'll cover Crime coverage. The following are covered:

- Definitions
- Crime coverage forms

The two types of crime coverage forms:

- The Loss sustained form
- The Discovery form

Fidelity bonds

Commercial crime insurance protects businesses and government entities from property losses due to crimes such as burglary, robbery, theft, and employee dishonesty.

Commercial crime insurance can be written as part of a Commercial Package Policy or as a standalone monoline policy.

Definitions

It is important to know the definitions of the different types of crimes that can be covered:

Burglary: The taking of property from inside the premises by a person unlawfully entering or leaving the premises with evidence of forcible entry or exit.

Safe burglary: The taking of property from a locked safe or vault inside the premises by a person unlawfully entering the safe or vault with evidence of forcible entry of the safe. This includes the removal of the safe from the premises.

Robbery: The taking of property in the care or custody of a person:

By force or threat of force, or by putting the victim in fear

By committing an obviously unlawful act that is witnessed by the person being robbed

Theft or Larceny: This is the broadest crime coverage and includes any act of stealing or unlawfully taking property. Theft includes burglary and robbery.

Forgery: Signing the name of another person or organization with the intent to deceive.

Extortion: The surrender of property away from the premises as a result of a threat communicated to the insured to do bodily harm to the insured, an employee, or relative of either the insured or the employee, who is allegedly being held captive.

The following persons are defined in the crime coverage forms:

Custodian: The insured or any of the insured's partners or employees while having care and custody of covered property while inside the premises. Custodian excludes a person while acting as a watchperson or janitor.

Messenger: The insured or any of the insured's partners or employees while having care and custody of covered property while outside the premises.

Watchperson: Any person the insured retains specifically for the purpose of having care and custody of covered property inside the premises and who has no other duties.

Employee: A person the insured compensates and has the right to direct in relation to the business.

The definition of premises is the interior of any building occupied by the insured for the purpose of conducting business.

The following types of property are specifically defined:

Money: Currency, coins, and bank notes in current use and having a face value, and travelers checks, registered checks, and money orders held for sale to the public.

Securities: Negotiable and non-negotiable instruments or contracts representing either money or other property, including tickets, stamps in current use, and evidences of debt in connection with the credit or charge cards other than cards issued by the insured.

Property other than money or securities: Any tangible property other than money and securities that has intrinsic value.

Coverage forms

The insured can select one or more crime coverage forms from the following:

Employee theft: Also known as employee dishonesty. Covers losses of or damage to money, securities, and other property resulting from the theft or forgery committed by an employee acting alone or in collusion with others.

This does not cover losses based on inventory shortages or profit and loss computations.

Losses may be covered on a per loss basis covering a single loss regardless of how many employees are involved in the loss, or on a per employee basis, covering the loss caused by a single employee.

Employee theft or employee dishonesty can also be covered using a fidelity bond. This is described below.

Forgery or alteration: Covers losses resulting from forgery or alteration of checks, drafts, promissory notes, or similar instruments made or drawn by or on the named insured or the insured's agent.

If the insured is sued for refusing to pay a forged or altered instrument and obtains the insurer's permission to defend the suit, the insurer will pay reasonable defense costs incurred by the insured. These expenses are paid in addition to the limit of liability.

In addition to the proof of loss, the insured must submit the instrument involved in the loss or an affidavit describing the amount and the cause of loss.

Inside the premises – theft of money and securities: Covers losses resulting from the theft, disappearance, or destruction of money while inside the insured premises or a banking premise.

If the insured owns the premises or is liable for damage to the premises, the insurer will cover damage to the interior and exterior of the premises that result from the theft or attempted theft. Damage will also be covered to a locked safe or vault inside the premises that result from the actual or attempted theft.

Inside the premises – robbery or safe burglary of other property: Covers loss of two types:

Loss of property, excluding money and securities, while inside the premises from actual or attempted robbery of a custodian.

Loss of property from a safe or vault inside the premises from actual or attempted safe burglary.

If the insured owns the premises or is liable for damage to the premises, the insurer will cover damage to the interior and exterior of the premises that result from the actual or attempted robbery or safe burglary. Damage will also be covered to a locked safe or vault inside the premises that result from the actual or attempted robbery or safe burglary.

Damage caused by a fire resulting from the burglary or robbery is not covered under the crime protection. This would be covered under the property coverage.

A $5,000 per occurrence limit applies to losses of precious metals, precious or semiprecious stones, furs, pearls, or other articles that contain these materials.

Outside the premises: Covers two types of losses:

Theft, disappearance, or destruction of money and securities while outside the premises and in the care and custody of a messenger or an armored car company.

Loss of property by actual or attempted robbery while outside the premises and in the care and custody of a messenger or an armored car company.

The insurer will only pay the amount of loss that cannot be recovered under the insured's contract with the armored car company and from any insurance available from the armored car company.

A $5,000 per occurrence limit applies to losses of precious metals, precious or semiprecious stones, furs, pearls, or other articles that contain these materials.

Computer fraud: Covers theft of property, including money and securities, directly related to the use of a computer to fraudulently cause a transfer from inside the premises to a person or place outside the premises. This coverage does not include employees or inventory shortages.

Money orders and counterfeit paper money: Covers losses when the insured accepts money orders or counterfeit paper money in good faith.

Funds transfer fraud: Covers losses resulting from fraudulent instructions to a financial institution to pay money from an insured's transfer account. This does not cover losses resulting from the use of a computer to transfer funds. This would cover funds transfers that were initiated, for example, by phone or written instruction. Fraudulent instructions are instructions by someone impersonating an insured or an employee to transfer money without the insured's knowledge or consent.

Limit of liability and deductibles

For each of the coverages selected, the insured must specify the limit of insurance and deductible applicable to the insuring agreement. These are listed in the declarations section of the policy.

The policy limit and deductible both apply per occurrence.

Exclusions

- The following exclusions apply to the crime coverage:
- Theft or dishonest acts committed by the insured, partners or members, whether acting alone or in collusion with others
- Loss caused by an employee if the employee had previously committed theft or a dishonest act prior to the policy period and the insured was aware of this
- Theft or dishonest acts committed by the insured's employees, managers, directors, trustees, or authorized representatives, except as covered under employee theft
- Unauthorized disclosure of the insured's confidential information
- Unauthorized use or disclosure of another party's confidential information that is held by the insured
- Seizure or destruction of property by government authority
- Indirect or consequential losses
- Legal expenses, other than those provided under forgery and alteration coverage
- Nuclear hazard
- Pollution
- War and similar actions

Conditions

Some of the general conditions that apply to crime coverage include:

- For loss or damage to property other than money and securities, the insurer will pay the lesser of the property's replacement cost or the limit of insurance. Replacement cost is the amount needed to repair or replace the property.
- Losses to money are paid at face value.
- Losses to securities are paid at market value at close of business on the day the loss was discovered. The insurer also has the option to replace them in kind.
- If other insurance applies to the loss and the crime coverage is written on a primary basis, the crime policy will pay its proportionate share of the loss if the other policy is written on the same basis as the crime policy. If the other policy was not written on the same basis, the crime policy pays on an excess basis.
- New employees and additional premises obtained through a consolidation, acquisition, or merger are automatically covered for 90 days provided the insured notifies the insurer and pays the additional premium.
- If the loss is covered by more than one coverage in the crime coverage form, the most the insurer will pay is the largest limit applicable to the loss
- The insured cannot take legal action against the insurer for 90 days after filing the proof of loss and legal action must be instigated within two years of the date of loss
- The coverage territory includes the United States and its territories and possessions, Puerto Rico, and Canada

The insured's duties in the event of a loss include:

- Notifying the insurer as soon as possible
- Notifying the police if a law may have been broken. This does not apply to employee theft or forgery and alteration coverage.
- Submitting to examination under oath as the insurer's request
- Providing a sworn proof of loss within 120 days
- Cooperating with the insurer in the investigation and settlement of the claim

Endorsements

Endorsements may be added to the crime protection as follows:

Extortion: Covers losses of money, securities, or property resulting from extortion.

Coverage includes damage to the insured premises or property inside the premises

Coverage is excluded if the loss occurs after the extortionist's demands have been made and the insured does not notify the local law enforcement or the FBI

Guests' property: Covers losses of money, securities, and other property owned by hotel guests while they are on the insured's premises, in the insured's possession, or in a safe deposit box on the insured's premises.

Loss sustained form and Discovery form

There are two different types of crime coverage forms. The major differentiator between the two forms is what triggers coverage. The two forms are:

Loss sustained form: Covers losses that are sustained during the policy period and discovered during the policy period or within one year after the policy expires.

The one-year discovery period terminates when the insured obtains other commercial crime insurance.

Losses that occur after the policy period would not be covered.

Discovery form: Covers losses that are sustained at any time and are discovered during the policy period or up to 60 days after the policy expires.

A loss is discovered when the insured first becomes aware that a loss has occurred or will occur even if they do not know the details, or receive notice of a claim or potential claim for a covered loss

This form is used to cover losses due to such crime losses as extortion or embezzlement that may not be discovered for several months or even years.

Discovery forms may require the use of a retroactive date, before which losses will not be covered.

The extended periods to discover losses terminate when the insured obtains other commercial crime insurance

Fidelity Bonds

Fidelity bonds are designed to protect an employer from dishonest acts or theft by an employee. The three parties involved in a Fidelity bond are the following:

The Principal or Obligor: The employee who is required to meet their obligations of honest performance of duties

The Surety or Guarantor: The party who guarantees that the Principal will perform as agreed, generally an insurance company

Obligee: The employer, the party who will be paid by the Surety if the Principal fails to perform as agreed.

Whereas with Surety bonds, the principal generally initiates the bond, with Fidelity bonds, the obligee, or employer initiates the bond.

Fidelity bonds will cover the following;

The loss by the employer of real and personal property such as cash, merchandise, autos, manuscripts

Property covered can be owned by the employer or in the care, custody, or control of the employer

Only direct losses. No consequential losses are covered by a Fidelity bond.

Losses based solely on inventory shortages or profit and loss statements are not covered. Fidelity bonds can be issued based on the requirements of the employer:

Individual bond: The employer bonds a single employee

Scheduled bond: The employer can name a number of employees or the job titles they wish to bond

Blanket bond: Covers all employees on a blanket basis.

E. Bonds

1. Surety

Overview: Surety bonds provide a financial guarantee that a party will fulfill their obligations as specified in a contract. If the obligated party fails to meet the terms, the surety company compensates the other party.

Example: A construction company is required to obtain a surety bond before starting a project to ensure they complete the work according to the contract. If the company fails to complete the project, the surety company pays the project owner.

2. Fidelity

Overview: Fidelity bonds protect businesses from financial losses due to dishonest acts committed by employees, such as theft or fraud.

Example: A fidelity bond covers losses for a retail store when an employee is found embezzling funds from the cash register.

Surety bonds are a type of financial guarantee that is commonly used in the construction industry to ensure that a project will be completed as specified in the contract. They provide protection to the project owner in case the contractor fails to fulfill their obligations.

For example, let's say a company hires a construction contractor to build a new office building. The project owner may require the contractor to obtain a surety bond before starting work. If the contractor fails to complete the project according to the agreed-upon terms, the surety bond will cover the costs of hiring a new contractor to finish the job.

Surety bonds can also be used in other industries, such as in the case of a contractor providing services to a government agency. In this situation, the surety bond serves as a guarantee that the contractor will perform the work as specified in the contract and comply with all regulations.

Overall, surety bonds provide peace of mind to project owners and help ensure that projects are completed successfully and on time.

F. Professional Liability

1. Errors and Omissions (E&O)

Overview: E&O insurance covers professionals against claims of negligence or inadequate work that results in financial loss for clients.

Example: A real estate agent is sued for failing to disclose a defect in a property, leading to significant repair costs for the buyer. E&O insurance covers the legal defense and settlement costs.

2. Medical Malpractice

Overview: Medical malpractice insurance protects healthcare professionals against claims of negligence or errors that result in patient injury or death.

Example: A surgeon is sued for performing an incorrect procedure. Medical malpractice insurance covers legal defense costs and any settlements or judgments.

3. Directors and Officers (D&O)

Overview: D&O insurance protects directors and officers of a company against claims of wrongful acts, such as mismanagement or breach of duty.

Example: A company's board of directors is sued by shareholders for financial losses due to alleged mismanagement. D&O insurance covers legal defense and any settlements or judgments.

4. Employment Practices Liability (EPLI)

Overview: EPLI provides coverage for claims arising from employment-related issues, such as discrimination, wrongful termination, or harassment.

Example: A former employee sues a company for wrongful termination, claiming discrimination. EPLI covers the legal defense and any settlements or judgments.

5. Cyber Liability and Data Breach, Funds Transfer

Overview: Cyber liability insurance covers losses due to data breaches, cyberattacks, and other technology-related risks.

Example: A company's data is breached, resulting in the exposure of customer information. Cyber liability insurance covers the costs of notifying customers, providing credit monitoring, and any legal fees.

6. Liquor Liability

Overview: Liquor liability insurance protects businesses that manufacture, sell, or serve alcohol against claims of damages or injuries caused by intoxicated patrons.

Example: A bar is sued after a patron causes a car accident while intoxicated. Liquor liability insurance covers the legal defense and any settlements or judgments.

Professional Liability insurance includes coverage for:

Malpractice:

Coverage for claims of negligence or errors in professional services.

Errors and Omissions:

Coverage for claims of mistakes or omissions in professional services.

As a business professional, it is essential to protect yourself and your business from potential risks and liabilities that may arise in the course of your work. One way to do so is by investing in professional liability insurance, also known as errors and omissions insurance. This type of insurance provides coverage for claims alleging negligence, errors, or omissions in the services you provide to clients.

Who needs Professional Liability Insurance?

Professional liability insurance is particularly crucial for certain professions that are at a higher risk of facing claims from dissatisfied clients. This includes but is not limited to:

Consultants: Consultants provide expert advice to clients, making them susceptible to claims if the advice given leads to financial loss or damages.

Accountants: Accountants are responsible for ensuring the accuracy of financial statements and tax returns, making them vulnerable to claims of errors or negligence.

Lawyers: Lawyers provide legal advice and representation to clients, and any mistakes or oversights in their work can result in malpractice claims.

Healthcare Professionals: Doctors, nurses, and other healthcare professionals are at risk of facing malpractice claims if patients are harmed due to errors in diagnosis or treatment.

Architects and Engineers: These professionals are responsible for designing and constructing buildings and infrastructure, making them liable for any design flaws or construction defects.

IT Consultants: IT consultants who provide software development, network security, or technical support services are at risk of facing claims for data breaches, system failures, or other IT-related issues.

Why do business professionals need Professional Liability Insurance?

Professional liability insurance is essential for business professionals for several reasons:

Protection against Lawsuits: In today's litigious environment, clients are quick to file lawsuits against professionals for alleged errors or negligence. Professional liability insurance helps cover legal fees, court costs, and settlements in the event of a lawsuit.

Financial Security: A lawsuit can be financially devastating for a business professional, potentially leading to bankruptcy or closure of the business. Professional liability insurance provides financial security by covering the costs associated with a claim.

Professional Reputation: Facing a lawsuit can damage a professional's reputation and credibility in the industry. Having professional liability insurance demonstrates to clients that you are committed to protecting their interests and mitigating risks.

Regulatory Compliance: Some industries require professionals to have professional liability insurance as part of their licensing or regulatory requirements. Failing to have the necessary insurance coverage can result in fines or disciplinary action.

In conclusion, professional liability insurance is a crucial risk management tool for business professionals in high-liability industries. By investing in this type of insurance, professionals can protect themselves, their businesses, and their clients from potential risks and liabilities. It provides financial security, legal protection, and peace of mind, allowing professionals to focus on their work without worrying about the possibility of a costly lawsuit.

Directors and Officers Liability

insurance provides coverage for claims against company executives for decisions made while managing the business.

Protecting Your Business: The Importance of Directors and Officers Liability Insurance

In today's complex business environment, the decisions made by directors and officers can have far-reaching consequences for a company and its stakeholders. With increasing regulatory scrutiny and a rise in shareholder activism, the need for Directors and Officers Liability Insurance (D&O insurance) has never been greater. But who exactly needs this type of coverage, and why is it so important?

Directors and officers are entrusted with the responsibility of making critical decisions that can impact the success and reputation of a company. However, with this responsibility comes the risk of being held personally liable for their actions or decisions. D&O insurance provides protection for these individuals in the event that they are sued for alleged wrongful acts, such as breach of fiduciary duty, negligence, or mismanagement.

While many business professionals may believe that their company's indemnification provisions or corporate insurance policies provide sufficient protection, the reality is that these may not always offer comprehensive coverage in the event of a lawsuit. D&O insurance is specifically designed to fill this gap and provide financial protection for directors and officers against legal expenses, settlements, and judgments.

Additionally, D&O insurance can also benefit the company itself by attracting and retaining top talent. Knowing that they are protected by comprehensive insurance coverage, directors and officers are more likely to take on leadership roles and make tough decisions without fear of personal liability. This can ultimately help to safeguard the company's interests and ensure its long-term success.

In today's litigious society, no company or individual is immune from the threat of a lawsuit. Whether you are a small startup or a multinational corporation, having D&O insurance in place is essential for protecting your business and its leadership. By investing in this type of coverage, you can mitigate the financial risks associated with legal actions and safeguard the future of your company.

In conclusion, Directors and Officers Liability Insurance is a valuable tool for protecting both individuals and companies from the risks and uncertainties of the business world. From legal expenses to reputational damage, the benefits of having this coverage in place far outweigh the costs. To learn more about how D&O insurance can benefit your business, speak to a qualified insurance professional today.

Employment Practices Liability

insurance covers claims of discrimination, harassment, or wrongful termination by employees.

Protect Your Business: The Importance of Employment Practices Liability Insurance

In today's competitive business environment, companies face a myriad of challenges when it comes to managing their workforce. From hiring and firing decisions to workplace harassment and discrimination claims, employers are constantly navigating potential legal pitfalls. This is where Employment Practices Liability Insurance (EPLI) comes into play.

EPLI is a type of insurance that provides protection to employers against claims made by employees alleging wrongful acts such as discrimination, harassment, wrongful termination, and other employment-related issues. In recent years, the number of employment-related lawsuits has been on the rise, making EPLI an essential safeguard for businesses of all sizes.

Businesses of all types and sizes can benefit from having EPLI coverage in place. However, certain industries are more susceptible to employment-related claims and lawsuits. For example, businesses in the healthcare, hospitality, and retail industries often deal with high turnover rates and diverse workforces, increasing the likelihood of potential disputes. Additionally, small businesses with limited resources may be particularly vulnerable to costly legal battles without EPLI protection.

There are several key reasons why businesses need EPLI coverage. Firstly, defending against an employment-related lawsuit can be a costly and time-consuming process. Legal fees, settlements, and damages can quickly add up, putting a significant financial strain on a business. EPLI can help cover these expenses, minimizing the financial impact of a lawsuit.

Secondly, even if a claim is ultimately found to be without merit, the mere accusation of wrongdoing can damage a company's reputation and brand. EPLI can provide coverage for public relations expenses to help mitigate the reputational damage caused by an employment-related claim.

Lastly, having EPLI coverage in place can also help attract and retain top talent. In today's job market, employees are increasingly aware of their rights and are more likely to seek legal recourse if they feel they have been wronged. By having EPLI coverage, businesses can demonstrate their commitment to creating a fair and inclusive work environment, which can help attract and retain employees.

In conclusion, Employment Practices Liability Insurance is a crucial risk management tool for businesses looking to protect themselves against the growing number of employment-related claims and lawsuits. By investing in EPLI coverage, businesses can safeguard their finances, reputation, and employees, ensuring long-term success and growth.

G. Umbrella/Excess Liability

Overview: Umbrella/excess liability insurance provides additional coverage beyond the limits of an underlying policy, offering extra protection against significant claims.

Example: A business faces a lawsuit that exceeds the limits of its general liability policy. Umbrella insurance covers the excess amount, providing additional financial protection.

Umbrella/Excess Liability

Insurance provides additional coverage above the limits of primary liability policies.

Understanding Commercial Umbrella and Commercial Excess Liability Insurance for P&C Insurance Agents

As a licensed Property and Casualty (P&C) insurance agent, it is crucial to have a comprehensive understanding of commercial umbrella and commercial excess liability insurance in order to properly advise your clients and provide them with the necessary coverage. These types of insurance policies offer additional protection beyond the limits of a primary liability policy and are essential for businesses of all sizes to safeguard their assets and mitigate risks.

Commercial umbrella insurance is designed to provide additional liability coverage that goes beyond the limits of a company's primary general liability, commercial auto liability, or employer's liability policies. In the event of a large liability claim or lawsuit, umbrella insurance can help protect a business from financial ruin by covering costs that exceed the limits of the primary policy. This type of policy is particularly valuable for businesses that face high risks of liability claims, such as those in the construction, healthcare, or manufacturing industries.

On the other hand, commercial excess liability insurance functions similarly to umbrella insurance in that it provides additional liability coverage above the limits of primary policies. However, commercial excess liability insurance typically follows the same terms and conditions as the underlying primary policy, whereas umbrella insurance may offer broader coverage. Commercial excess liability insurance is often purchased by businesses that require higher liability limits but do not need the additional coverage offered by umbrella insurance.

It is important for P&C insurance agents to educate their clients on the differences between commercial umbrella and commercial excess liability insurance, as well as the benefits of each type of coverage. By understanding the specific needs and risks of each individual business, agents can tailor insurance packages that provide the appropriate amount of coverage to protect against potential liabilities.

When advising clients on commercial umbrella and commercial excess liability insurance, P&C insurance agents should consider factors such as the size and nature of the business, the industry in which it operates, and the potential risks it faces. Agents should also be knowledgeable about the various policy limits, deductibles, and coverage options available, as well as any exclusions or limitations that may apply.

In conclusion, commercial umbrella and commercial excess liability insurance are essential components of a comprehensive risk management strategy for businesses. By working closely with their clients to assess their specific insurance needs and recommend appropriate coverage options, P&C insurance agents can help businesses protect their assets and minimize financial risks in the event of a liability claim or lawsuit.

Personal Liability and Other Personal Exposures

Umbrella / Excess Liability

An umbrella policy provides liability insurance that is in excess of insurance specified in other primary policies and may potentially provide primary insurance for losses not covered by other policies.

Personal Homeowners and Auto policies provide coverage for personal liability for bodily injury and property damage up to specified limits. There is still a demand for liability coverage with higher limits. A personal umbrella policy provides this coverage at very low premiums. Typically an umbrella policy will provide liability insurance for $1,000,000 or more.

An umbrella policy provides excess liability insurance over and above the limits of liability covered by the primary policies. That is the primary policy will pay up to its limits of liability in the case of a claim. If the insured is liable for more than the limit of liability on the primary policy, the umbrella policy will pay any excess up to its limits of liability. Some underwriters require a minimum amount of liability coverage on the primary policy, for example. $300,000.

An umbrella policy can also provide primary insurance for other areas of liability the insured may become responsible for. In this case, the insured is generally required to pay a retention requirement, the equivalent of a deductible. They may, for example, have a deductible of $1,000 but this could be higher.

Following are some examples of liability coverage that may be requested under a personal umbrella policy:

- To extend personal liability coverage beyond the United States to include worldwide coverage
- To provide Personal injury insurance
- To provide coverage for small watercraft, jet skis, or snowmobiles
- To cover someone who does not have insurance
- To provide coverage even when a lawsuit is groundless or not covered by the underlying policy
- If you serve on a board of directors or for a non-profit organization
- If you often have guests in your home
- If you have a teenage driver in your household
- If you are a member of a homeowners' association

Some exclusions apply to personal umbrella policies such as intentional acts or liability associated with a business pursuit.

Umbrella policies are usually written on an occurrence basis and have an aggregate limit.

H. Business Owners Policy (BOP)

Overview: A BOP combines various coverages into a single policy, typically including property, liability, and business interruption insurance. It's designed for small to medium-sized businesses.

Example: A small bakery purchases a BOP that covers damage to the bakery, liability for customer injuries, and lost income due to business interruption.

V. CASUALTY: INSURANCE TERMS AND RELATED CONCEPTS

A. Risk

Overview: Risk refers to the uncertainty regarding financial loss. In the context of insurance, it is the chance of a loss occurring that a policyholder or insurer must consider.

Example: A business owner assesses the risk of a fire damaging their warehouse and decides to purchase insurance to mitigate that risk.

B. Hazards

Overview: Hazards are conditions or situations that increase the likelihood or severity of a loss.

Example: Storing flammable materials improperly can be a hazard that increases the risk of fire.

1. Moral Hazard

Overview: Moral hazard refers to the risk that an insured party may behave recklessly or dishonestly because they have insurance coverage.

Example: An insured driver may engage in risky driving behavior because they know their insurance will cover any damages.

2. Morale Hazard

Overview: Morale hazard refers to the risk arising from the insured party's indifference to loss because of the presence of insurance.

Example: An employee leaves a company laptop in an unlocked car, feeling secure that any theft would be covered by insurance.

3. Physical Hazard

Overview: Physical hazard refers to tangible conditions that increase the probability or severity of a loss.

Example: An old, faulty electrical system in a building poses a physical hazard by increasing the likelihood of a fire.

C. Indemnity

Overview: Indemnity is a principle in insurance that ensures that the insured is restored to their financial position before the loss occurred, without profiting from the insurance claim.

Example: After a car accident, the insurance company pays for the repairs to the insured's vehicle, restoring it to its pre-accident condition.

D. Insurable Interest

Overview: Insurable interest is a legal principle that requires the policyholder to have a financial or other significant interest in the insured item or person, meaning they would suffer a loss if the item is damaged or the person is harmed.

Example: A homeowner has an insurable interest in their house because they would suffer a financial loss if it were damaged or destroyed.

E. Loss Valuation

1. Actual Cash Value

Overview: Actual Cash Value (ACV) is the value of an insured item, considering depreciation. It represents the item's market value at the time of the loss.

Example: If a five-year-old laptop is stolen, ACV would be the cost of a new laptop minus five years of depreciation.

2. Replacement Cost

Overview: Replacement Cost is the amount required to replace an insured item without considering depreciation.

Example: If a homeowner's roof is damaged by a storm, replacement cost coverage would pay for a new roof of similar kind and quality.

3. Market Value

Overview: Market Value is the amount a buyer would be willing to pay for property in the open market.

Example: The market value of a house is $300,000 based on recent sales of similar homes in the area.

4. Stated/Agreed Value

Overview: Stated Value is a value agreed upon by the insurer and the insured at the time the policy is written. The insurer will pay this amount in the event of a total loss.

Example: A classic car is insured for an agreed value of $50,000, and this amount will be paid if the car is totaled.

5. Salvage Value

Overview: Salvage Value is the estimated resale value of an item after it has been deemed a total loss.

Example: After a car accident, the salvage value of the damaged vehicle is determined to be $2,000.

F. Negligence

Overview: Negligence is the failure to exercise reasonable care, resulting in damage or injury to another party.

Example: A store owner fails to clean up a spill, causing a customer to slip and fall. The store owner may be found negligent.

G. Liability

Overview: Liability refers to the legal responsibility for damages caused to another party.

Example: A driver is found liable for damages after causing a car accident.

H. Occurrence

Overview: An Occurrence is an event or series of events that result in a loss or damage, triggering coverage under an insurance policy.

Example: A burst pipe causes water damage to a home. The burst pipe is the occurrence that triggers the insurance claim.

I. Binders

Overview: A Binder is a temporary insurance contract that provides coverage until a formal policy is issued.

Example: A homebuyer receives a binder from their insurance agent to cover the property during the closing process.

J. Warranties

Overview: Warranties are conditions or promises in an insurance contract that must be met for coverage to be valid.

Example: A warranty in a marine insurance policy requires the insured to maintain a specific level of crew experience.

K. Representations

Overview: Representations are statements made by the insured during the application process that are believed to be true.

Example: An applicant states they have no history of filing insurance claims when applying for homeowners' insurance.

L. Concealment

Overview: Concealment is the intentional withholding of material information that is crucial for underwriting an insurance policy.

Example: A business owner fails to disclose a previous fire at their premises when applying for property insurance.

M. Deposit Premium/Audit

Overview: A Deposit Premium is an initial payment made for an insurance policy, which may be adjusted based on an audit of actual exposures.

Example: A construction company pays a deposit premium for workers' compensation insurance, which is later adjusted based on the actual payroll during the policy period.

N. Certificate of Insurance

Overview: A Certificate of Insurance is a document that provides evidence of insurance coverage.

Example: A contractor provides a certificate of insurance to a client to show proof of liability coverage.

O. Law of Large Numbers

Overview: The Law of Large Numbers is a statistical principle that states that the larger the number of exposure units, the more predictable the losses become.

Example: An insurance company can more accurately predict the number of claims for a large pool of insured homes compared to a small pool.

P. Pure vs. Speculative Risk

Overview: Pure Risk involves only the possibility of loss or no loss, while Speculative Risk involves the possibility of loss, no loss, or gain.

Example: Pure Risk: The risk of a house fire. Speculative Risk: The risk of investing in the stock market.

Q. Endorsements

Overview: Endorsements are additions or modifications to an insurance policy that alter the coverage.

Example: An endorsement is added to a homeowner's policy to provide coverage for a home-based business.

R. Damages

1. Compensatory

a. General

General damages compensate for non-monetary losses such as pain and suffering.

Example: A person receives general damages for pain and suffering after a car accident.

b. Special

Special damages compensate for specific monetary losses such as medical bills and lost wages.

Example: A person receives special damages to cover medical expenses and lost income after an injury.

2. Punitive

Overview: Punitive damages are awarded to punish the defendant for egregious conduct and deter future misconduct.

Example: A company is ordered to pay punitive damages for knowingly selling a dangerous product.

S. Compliance with Provisions of Fair Credit Reporting Act

Overview: This refers to the requirement that insurers comply with the Fair Credit Reporting Act (FCRA) when using consumer credit information for underwriting or rating purposes.

Example: An insurance company must inform an applicant if their credit report was used to deny coverage or determine premiums, and provide information on how to obtain a copy of the report.

VI. CASUALTY: POLICY PROVISIONS

A. Declarations

Definition: The declarations page of an insurance policy provides a summary of the key details of the policy, including the names of the insured and insurer, the coverage limits, the premium amount, and the policy period.

Example: The declarations page of a homeowner's insurance policy lists the insured's name, the address of the insured property, the coverage limits for the dwelling and personal property, and the annual premium.

An insurance declarations page is a summary of your insurance policy in one or two pages. It lets you know what's covered, who's covered and how much you're going to pay for coverage.

Declarations pages are also called "dec pages" for short. There are differences between auto insurance, homeowners' insurance and renters' insurance declarations pages.

Auto insurance declarations page

An auto insurance declarations page is an overview of your car insurance policy, but it doesn't contain all the fine points. Those are laid out in other sections of the policy, which go into much greater detail.

- Your car insurance declarations page will contain information about:
- When the policy is valid.
- What vehicles are covered.
- Which drivers are covered.
- What your coverage limits are.
- What your deductibles are.
- How much your premium is.
- What discounts you've received.
- Any optional coverage you have.

These facts are all presented at a summary level. For instance, your coverage limits might list bodily injury liability coverage of $30,000 per person and $60,000 per accident. The declarations page won't say that this coverage doesn't apply when you intentionally attempt to harm someone or that you won't be covered when using your car for business.

Exceptions are laid out in the policy details pages. You'll know you've found the details of your policy when you find page after page of numbered paragraphs, subsections and sections where words like "you" are defined.

The dec page is meant to be a quick overview of your policy. It's also an easy place to start understanding all of the parts of your coverage. You can see at a glance if you have the coverage you need and how much you're currently paying.

Your declarations page also might contain contact details for your agent, information about your premium payment schedule and names of any drivers specifically excluded from the policy.

Whenever you compare car insurance quotes, it makes sense to keep a copy of your declarations page nearby.

Homeowners insurance declarations page

A homeowners insurance declarations page is similar in layout to an auto insurance declarations page. You'll see details about your policy such as who and what's covered. You'll also see your premium and any discounts you've received.

Renters insurance declarations page

The declarations page for renters' insurance looks very much like a homeowners insurance declarations page. The main difference is in the types of coverage you'll see and the lack of any mortgage details.

A renters insurance declarations page will cover:

- When the policy is in force.
- What your personal property limits are.
- What your deductible is.
- How much your premium is.
- Any discounts you're receiving.
- Any additional coverage options.

The main difference between renters and homeowners' insurance is that renters insurance covers the stuff in your rental, like your clothes, furniture and electronics but not the property you live in. Landlords will have insurance to cover the building in case of fire or another catastrophe.

Renters insurance also covers you for any damage you might cause to the property or to people on the property.

B. Insuring Agreement

Definition: The insuring agreement is the section of an insurance policy that outlines the insurer's promise to pay for covered losses in exchange for the premiums paid by the insured.

Example: In an auto insurance policy, the insuring agreement may state that the insurer will cover damages resulting from collisions, theft, and other specified perils.

C. Conditions

Definition: Conditions are the provisions in an insurance policy that outline the duties and responsibilities of both the insured and the insurer.

Example: A condition in a homeowner's policy may require the insured to report a loss within a certain time frame and to protect the property from further damage. For more information, visit The Balance[3].

D. Exclusions and Limitations

Definition: Exclusions are specific situations or perils that are not covered by an insurance policy.

Example: A homeowner's insurance policy may exclude coverage for flood damage, meaning any damage caused by flooding would not be covered.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS 

E. Definition of the Insured

Definition: The insured is the person or entity covered by an insurance policy.

Example: In a homeowner's insurance policy, the insured typically includes the policyholder and their family members living in the same household.

The important points

- Insured refers to anyone covered by the policy, whether they're specifically named or not.
- Different insurance companies define "insured" differently.

In insurance, the insured is the person or business that is covered by an insurance policy. One policy can (and usually does) cover multiple insureds.

Example

Stanley is a homeowner who lives with his two kids, his wife, and her father. Stanley bought the insurance policy that protects their home, and it's his name written on the front of the policy. However, his insurance policy extends coverage to Stanley's partner, his relatives, and his partner's relatives, as long as they're living with him in the house.

In this example, Stanley is the named insured: his name specifically appears on the policy. The terms of his home insurance policy extend coverage to the other people living with him: his kids, his wife, and his father-in-law are all considered insureds under his policy, even though the policy doesn't name them specifically.

Policies of insurance always have a named insured, and sometimes more than one. Plus, insurance policies often extend coverage to people who aren't actually named on the policy.

Home insurance policies typically cover family members of the named insured if they're living in the same household. Commonly, children who are living away from home for school are also insured.

Insurance companies often differ slightly in their definition of insured. You'll be able to find your insurer's definition somewhere in your policy wordings.

The definition of an insured includes the named insured, plus:

- Living in the same household:
- The named insured's partner
- Relatives of the named insured or their partner
- Anyone under 21 years old in the care of the named insured or their partner
- Any domestic employees
- Living outside the household:

- The parents of the named insured or their partner, while they live in a residential care facility
- Any students who are dependent on the named insured or their partner

What is the difference between insured and insurer?

Now that we've defined insured, what's an insurer?

An insurer is the company that is insuring the insured. Or, less confusingly: the insurer is the company that agrees to cover the insured's claims under the policy. If the insured makes a claim, the insurer is the one who pays the claim settlement.

Often, the insurer will be the same company that sold the policy, though not always.

If you bought your insurance policy through a broker, that broker is not your insurer. The insurer is the company that underwrites the policy and pays any claims. Your insurer is clearly identified on your policy's declarations page.

F. Duties of the Insured After a Loss

Definition: These are the responsibilities that the insured must fulfill after experiencing a loss to ensure coverage under the policy.

Example: After a fire, the insured must promptly notify the insurer, protect the property from further damage, and provide a detailed inventory of damaged items.

What Does Duties of The Insured Mean?

Duties of the insured refer to the responsibilities of the policyholder, which generally requires the exercise of good faith and maintenance of fair dealing. These duties are often listed in the conditions section of the insurance contract.

Some of the duties of the insured include the following:

- Disclose material information,
- Avoid concealment and misrepresentation,
- Report loss or damage to the authorities,
- Provide notice of claim to the insurer,
- Prepare an inventory of the damaged or stolen property, and
- Provide proof of loss to the insurer.

The inability of the insured to comply with their duties is a ground for breach of contract, cancellation of the policy, and forfeiture of the premiums paid.

Obligations of the Insurance Company

Definition: These are the duties that the insurer must fulfill as part of the insurance contract, including investigating claims and paying covered losses.

Example: The insurer must investigate a claim promptly and pay the claim if it is covered under the policy terms.

The Responsibilities of an Insurance Company

In addition to the duties outlined in your policy, insurance companies have responsibilities under both common law and statutory law. In general, the insurance company owes you a duty of good faith and fair dealing when handling any transaction. It also has the obligation to faithfully investigate and honor valid insurance claims.

Fair Deal

An insurance company's duty of good faith and fair dealing means it must always act in the client's best interest. This responsibility, implied in all insurance agreements, prevents the company from acting in bad faith in transactions involving your claim. If it breaches this responsibility you are entitled to sue for damages.

General Duties

An insurance company has a legal duty to fully investigate your claim, not just the parts that support their position. It must also provide you with all necessary information so you can protect your claim under the policy.

Additionally, the company must respond to your communications and promptly pay your claim if it's found valid.

Insurance Contract

Your insurer must honor any responsibilities outlined in your policy. It's free to provide you with rights above and beyond those provided by law, so your agreement may have extra responsibilities. Additionally, if a provision in your policy is found to be ambiguous it's interpreted by a court as being in your favor if there's a dispute.

Duty to Defend

Depending on the nature of your agreement, your insurer may have a duty to indemnify or defend you under certain circumstances. The duty to defend provides you with legal representation if you're sued. The duty to indemnify pays for any legal judgments against you. Both are dictated by the terms of your policy.

Mortgagee Rights

Definition: Mortgagee rights are the protections provided to a mortgage lender under a property insurance policy.

Example: If a home with a mortgage is damaged, the insurance company will pay the mortgage lender for the loss before the homeowner.

Mortgagee Clause: What it Means, How it Works, Example

A mortgagee clause is found in many property insurance policies, and it provides protection for a mortgage lender if a property is damaged.

Normally, you will be asked to agree to a mortgagee clause when you take out a mortgage.

In effect, a mortgagee clause is a separate agreement between your mortgage lender (the mortgagee) and the insurance company that is insuring your property. A mortgagee clause ensures that if your property is damaged while you are paying off the mortgage, the insurance company will pay your mortgage lender for this loss, even though it’s covered on your insurance policy.

A lender would not lend a substantial amount of money secured by property without the inclusion of a mortgagee clause in the borrower's property insurance policy, so they are an important part of your mortgage and property insurance contracts.

Key Takeaways

A mortgagee clause is a part of your homeowners insurance policy that protects your lender—the mortgagee—from losses incurred due to damage to your property.

Many mortgage providers require a mortgagee clause in place to grant a mortgage.

A mortgagee clause states that if a property is damaged during the mortgage period, the insurance company must pay the mortgagee for this.

For example, if you obtain a mortgage to buy a home or property and that property is then destroyed in a fire, the mortgagee clause would ensure that the loss would be payable to your lender even though it's part of your insurance policy.

What Is a Mortgagee Clause?

Most mortgage providers (mortgagees) will require you (the borrower, or mortgagor) to take out homeowners' insurance to get a loan. Homeowners insurance provides you with protection against damage to your property and its contents, but it also provides protection for your lender. The mortgagee clause is a key part of these protections.

A mortgagee clause states that if a property is damaged during the mortgage period, the insurance company must pay the mortgagee for this. For example, if you obtain a mortgage to buy a home or property and that property is then destroyed in a hurricane, the mortgagee clause would ensure that the loss would be payable to your lender even though it's part of your standard insurance or hurricane insurance policy.

This clause also protects the lender if you cause damage to the property, which leads the insurance provider to cancel the policy. Fire damage is one of the most common causes of home damage and is usually protected by insurance. But not when the damage is caused intentionally. If you commit arson—an act that would void your insurance policy—the clause protects the mortgagee, ensuring that your lender will still be covered.

Who's Who

It's important to understand the terminology used in mortgage negotiations. A mortgagor is a borrower. A mortgagee is a lender that provides a mortgage loan to a mortgagor.

How a Mortgagee Clause Works

Most lenders require that borrowers have homeowners' insurance and that the insurance policy include a mortgagee clause. The policy will state who has the lien within the policy. In some cases, if it's not a requirement to get a mortgagee clause, then a borrower must contact a lender to add the clause to their current contract.

Mortgagee clauses provide valuable protection for lenders because of the way that mortgages work. When you take out a mortgage, you are essentially offering your home as collateral for a loan, which you promise to pay back. If you can't keep that promise, then your lender (the mortgagee) can foreclose on the property and sell it to recoup costs. But if the property is damaged, then the mortgagee's investment is put in jeopardy. The mortgagee clause ensures that the mortgagee will be paid out even if you are responsible for the damage to the property.

In other words, a mortgagee clause is a form of indemnity protection for the lender, because if there is any loss or damage to the collateral property, the lender is indemnified up to the interest that it has in that property.

Mortgagee clauses are an important component of the mortgage market. Without the protection of the mortgagee clause, financial institutions would be unlikely to loan the large amounts of money necessary to purchase homes, office buildings, or factories.

What Is an Example of a Mortgagee Clause?

Mortgagee clauses protect your lender from damage to your property, even if you caused it. So, if you commit an intentional criminal act that voids your insurance policy, the clause protects the mortgagee, ensuring that your lender will still be covered.

Is the Mortgagee the Borrower?

No. A mortgagee is a lender—specifically, an entity that lends money to a borrower for the purpose of purchasing real estate. In a mortgage transaction, the lender serves as the mortgagee and the borrower is known as the mortgagor.

Can a Person Be a Mortgagee?

Yes. Anyone who lends you money to buy a home and enters into a mortgage contract with you can be a mortgagee. When you sign a mortgage contract with an individual, it's called a private mortgage.

The Bottom Line

A mortgagee clause is a part of your homeowners insurance policy that protects your lender (the mortgagee) from losses incurred due to damage to your property. Many mortgage providers will require a mortgagee clause to grant you a mortgage.

A mortgagee clause states that if a property is damaged during the mortgage period, the insurance company must pay the mortgagee for this.

G. Cancellation and Nonrenewal Provisions

Overview: These provisions outline the circumstances and procedures under which an insurance policy can be canceled or not renewed by either the insurer or the insured. Cancellation refers to ending the policy before its expiration date, while nonrenewal refers to the decision not to renew the policy at the end of the policy term.

Example:

- **Cancellation:** An insurer cancels a policy mid-term due to non-payment of premiums. They provide a written notice to the insured specifying the reason and the effective date of cancellation.
- **Nonrenewal:** An insurer decides not to renew a policy because the insured has filed multiple claims. They send a notice of nonrenewal to the insured, explaining the reason and providing sufficient notice before the policy's expiration date.

H. Supplementary Payments

Overview: Supplementary payments are additional costs covered by an insurance policy beyond the policy limits. These payments often include expenses such as defense costs, court costs, interest on judgments, and reasonable expenses incurred by the insured at the insurer's request. **Example:**

- A liability insurance policy covers a lawsuit against the insured. The supplementary payments cover the cost of hiring a defense attorney, court fees, and any interest on the judgment awarded against the insured, in addition to the policy's liability limits.

I. Proof of Loss

Definition: A proof of loss is a formal statement made by the insured to the insurer regarding a claim, detailing the extent of the loss and the amount being claimed.

Example: After a burglary, the insured submits a proof of loss form listing the stolen items and their values.

What is proof of loss?

A proof of loss is a formal document you must file with an insurance company that initiates the claim process after a property loss. It provides the insurer with specific information about an incident – its cause, resulting damage, and financial impact. Once the insurer has received the proof of loss, it can send you a check for repairing or replacing your damaged item if it is covered with your policy.

Is proof of loss required for all types of insurance?

Insureds must file a proof of loss form to receive benefits under a commercial property insurance policy. All forms of insurance have a similar process for notifying insurers when a loss occurs. This includes:

- General liability insurance
- Business owner’s policy
- Workers’ compensation insurance
- Commercial auto insurance
- Business interruption insurance
- And many other types of small business insurance.

What should a proof of loss form include?

Each carrier has a specific form or a preferred format for submitting a proof of loss. Generally, you must provide your insurer with a complete description of the loss, including:

- Date and time
- Incident precipitating the loss (storm, flood, theft, etc.)
- Property involved in the loss
- Nature and scope of damage incurred
- Evidence of the loss (photos, police report, purchase receipts)
- Current property replacement value

- The party (or parties) with a financial interest in the property

The insurer will then process the form and determine how much it will offer the insured as a claim settlement.

When should you file your proof of loss with your insurer?

Under the proof of loss policy provision, you must file your form as soon as possible after the incident, but no later than the date specified in your policy (often 60 days).

Can your insurer refuse to accept your proof of loss form?

Your insurer can refuse to process your proof of loss form in the following cases:

- You didn't answer all the questions.
- You failed to include supporting documentation.
- You didn't sign the form.
- You didn't have your signature notarized.

In these instances, the company might return the form to you for revisions. However, it can't reject your form just because it doesn't like the amount of benefits you're requesting.

What happens after you file your proof of loss?

Your insurance proof of loss form kicks off a formal claims process. It typically includes the following steps:

- Your insurer reviews your proof of loss and attached documentation.
- The insurance company determines whether your policy covers the claimed items. For example, if your policy covers named perils only and the loss isn't named, there will be no coverage.
- A financial value is assigned to each item, either based on a replacement cost or actual cash value.
- The carrier totals the value of all items and offers to settle the claim for the bottom-line amount.
- You will have a chance to review your insurer's offer and decide whether or not to accept it.
- If you don't accept it, you can negotiate with the insurer for a larger settlement.
- If you accept its settlement offer, the insurance company will now apply your deductible (your share of the loss) to that amount.

J. Notice of Claim

Definition: A notice of claim is a formal notification to the insurer that a loss has occurred, and a claim is being made.

Example: After a car accident, the insured sends a notice of claim to their auto insurance company to start the claims process.

What is a Notice of Insurance Claim?

Navigating an accident claim can be overwhelming, but understanding the importance of a Notice of Insurance Claim can pave the way to securing your rightful compensation.

Accidents can be distressing, especially when they result from someone else's negligence.

A crucial step in securing the compensation you deserve following an accident is submitting a "Notice of Insurance Claim" to the at-fault party's insurance provider.

A "Notice of Insurance Claim" is a formal written notice that the claimant (you) sends to an insurance company (the "insurer"). It informs the insurer about your intention to file an insurance claim for an injury caused by their policyholder (the "insured").

This document is often the initial step in the process of pursuing a personal injury claim. It helps by properly documenting your claim and establishing a clear communication line with the insurance company.

When is a Notice of Insurance Claim appropriate?

A Notice of Insurance Claim is applicable in almost any case in which someone else was at fault for your injuries. This may include:

- Accidents involving children
- Car accidents
- Truck accidents
- Slip and fall cases
- Boating accidents
- Bicycle accidents
- Motorcycle accidents

When to send a Notice of Insurance Claim

It's important to send a Notice of Insurance Claim to the insurer as soon as possible after suffering your injury. Doing so ensures that the incident is still fresh in your mind and the pertinent details are correct. What's more, insurance companies (and jurors) tend to take allegations more seriously when they are raised without delay.

It's a good idea to send the Notice of Insurance Claim via certified mail with a return receipt requested so you have proof that it was received.

Every state has a statute of limitations that requires plaintiffs to file a lawsuit within a certain period of time, or else the lawsuit will be forever barred. It's important to keep in mind that a Notice of Insurance Claim is NOT a substitute for a lawsuit and, therefore, will not stop the statute of limitations from running.

Key elements of the Notice of Insurance Claim

Your Notice of Insurance Claim should include a few essential details, including:

- Your contact information
- The date of the accident
- A brief description of the accident
- A brief description of the injuries sustained
- It's also important to request a written confirmation of the liability insurance coverage for the insured for the date of the accident and whether the insured contends that anyone other than themselves may be liable.

K. Other Insurance

Definition: An other insurance provision specifies how coverage will be apportioned if multiple insurance policies cover the same risk.

Example: If a person has two health insurance policies, the other insurance provision determines which policy pays first and how much the second policy will cover.

What Does Other Insurance Clause Mean?

An other insurance clause is a provision included in insurance policy contracts that specifies exactly how much coverage the policy offers if the insured has another policy that covers the same risk. Depending on the clause, the insurers may share coverage or one policy may be sufficient.

Other Insurance Clause

The other insurance clause is a protection against overinsurance, a situation in which multiple insurers pay out claims for the same loss. Overinsurance would allow an insured to earn a profit from their insurance policies.

Usually, one policy is assigned as the primary insurance. The primary insurance is the first coverage that will come into effect when the policyholder suffers an insured loss. If the primary policy is exhausted and has not been able to pay for the entire loss, the other policies will provide additional coverage for the remaining loss.

Policyholders are advised to read the other insurance clause carefully because it might notify them that the policy will not provide coverage if another policy covers the same risk.

L. Subrogation

Definition: Subrogation is the legal right held by insurers to pursue a third party that caused an insurance loss to the insured.

Example: After paying for damages from a car accident, an insurance company sues the at-fault driver to recover the costs.

M. Loss Settlement Provisions Including Consent to Settle a Loss

Loss Settlement Provisions

Overview: Loss settlement provisions are clauses within an insurance policy that outline the process and methods used to determine the amount paid for a claim. These provisions specify the basis of payment, such as actual cash value, replacement cost, or agreed value, and any applicable conditions or limitations.

Example:

- **Actual Cash Value:** After a car accident, the insurance company assesses the market value of the vehicle minus depreciation to determine the payout.
- **Replacement Cost:** A homeowner's policy specifies that the insurer will pay the cost of replacing damaged property with new items of similar kind and quality without considering depreciation.
- **Agreed Value:** For a valuable art piece, the insurer and insured agree on a value at the start of the policy. In case of a loss, this agreed value is paid out.

Consent to Settle a Loss

Overview: Consent to settle a loss is a provision that requires the insurer to obtain the insured's permission before settling a claim. This provision protects the insured's interests, ensuring they agree with the proposed settlement amount and terms.

Example:

- **Scenario:** A professional liability insurance policy for a consultant includes a consent to settle clause. If a client sues the consultant for alleged negligence, the insurer must seek the consultant's approval before agreeing to any settlement with the client. This allows the consultant to have a say in the resolution and ensure it does not negatively impact their reputation or future business prospects.

These provisions are critical in ensuring that the insured understands how claims are settled and has a say in the settlement process.

N. Terrorism Risk Insurance Act (TRIA)

Definition: TRIA is a federal law that provides a government backstop for insurance claims related to acts of terrorism.

Example: After a terrorist attack, TRIA ensures that insurance companies can cover the losses without going bankrupt.

The Terrorism Risk Insurance Act (TRIA) (H.R. 3210, Pub. L.Tooltip Public Law (United States) 107–297 (text) (PDF)) is a United States federal law signed into law by President George W. Bush on November 26, 2002. The Act created a federal "backstop" for insurance claims related to acts of terrorism. The Act "provides for a transparent system of shared public and private compensation for insured losses resulting from acts of terrorism."[1] The Act was originally set to expire December 31, 2005, was extended for two years in December 2005, and was extended again on December 26, 2007. The Terrorism Risk Insurance Program Reauthorization Act expired on December 31, 2014.[2]

VII. Georgia State Laws, Rules, and Regulations Pertinent to All Insurance Lines

A. Insurance Department and Commissioner

1. Broad Powers and Duties

Overview: The Georgia Insurance Department and Commissioner have the authority to regulate and oversee the insurance industry within the state. This includes issuing licenses, approving policy forms, ensuring compliance with state laws, and protecting consumers.

Example: The Commissioner may issue a cease and desist order to an insurance company that is found to be engaging in unfair trade practices.

Reference: [O.C.G.A. § 33-2-1 through 6, 9 through 32]

2. Examination of Records

Overview: The Insurance Commissioner has the authority to examine the books, records, and financial affairs of any insurance company operating in Georgia to ensure compliance with state laws and regulations.

Example: The Commissioner conducts a routine audit of an insurance company's financial records to ensure they are maintaining adequate reserves and adhering to accounting standards.

Reference: [O.C.G.A. § 33-2-10 through 13]

3. Investigations/Notice of Hearing

Overview: The Insurance Commissioner can investigate any suspected violations of insurance laws. If a violation is found, the Commissioner will provide a notice of hearing to the involved parties.

Example: An investigation is launched into an insurance company suspected of denying valid claims. The company receives a notice of hearing to address the allegations.

Reference: [O.C.G.A. § 33-6-6]

4. Penalties

Overview: The Insurance Commissioner has the authority to impose penalties, such as fines or license suspensions, on insurance companies or agents that violate state laws or regulations.

Example: An insurance agent is fined and has their license suspended for fraudulently misrepresenting policy terms to customers.

Reference: [O.C.G.A. § 33-6-9]

B. General Insurance Definitions

1. Domestic, Foreign, and Alien

Overview: These terms classify insurance companies based on their origin of incorporation:

- **Domestic:** Incorporated within the state.
- **Foreign:** Incorporated in another state.
- **Alien:** Incorporated in another country.
- **Example:** A company incorporated in Georgia is a domestic insurer in Georgia, a foreign insurer in Alabama, and an alien insurer in Canada.

- **Reference:** [O.C.G.A. § 33-3-1]

2. Stock and Mutual

Overview: These terms define the ownership structure of insurance companies:

- **Stock Insurance Company:** Owned by shareholders.
- **Mutual Insurance Company:** Owned by policyholders.
- **Example:** A stock insurance company pays dividends to shareholders, while a mutual insurance company may return excess profits to policyholders in the form of dividends or reduced premiums.
- **Reference:** [O.C.G.A. § 33-14-2]

3. Authorized/Unauthorized and Certificate of Authority

Overview: An authorized insurer has a Certificate of Authority to operate in the state, while an unauthorized insurer does not.

Example: An insurance company with a Certificate of Authority can legally sell policies in Georgia. An unauthorized company cannot.

Reference: [O.C.G.A. § 33-3-2 through 5; § 33-3-13 through 30]

4. Insurance Transaction / Transacting Business

Overview: This term encompasses various activities related to the sale and management of insurance policies, including solicitation, negotiation, and servicing.

Example: An agent who discusses policy options with a prospective client, helps them complete an application, and processes the policy issuance is transacting business.

Reference: [O.C.G.A. § 33-1-2]

C. Licensing of agents, counselors, subagents, and adjusters

1. Agent Responsibility

Agents are responsible for selling insurance products and assisting consumers with applications and enrollments. They must comply with state laws and regulations, maintain their licenses, and adhere to ethical standards1.

2. License Maintenance

Agents must renew their licenses annually or biennially, depending on the type of insurance they sell. They must also complete continuing education requirements to maintain their licensure2.

3. License Revocation, Suspension, Denial, or Refusal to Renew

A license may be refused, suspended, or revoked if the agent violates state laws, misrepresents information, engages in fraudulent practices, or fails to comply with regulations. Grounds for refusal or revocation include dishonesty, incompetence, and failure to pay over money due to insurers or insureds3.

4. Temporary License

Temporary licenses may be issued under certain circumstances, such as when an agent is waiting for their permanent license to be processed or when they need to continue business operations temporarily.

5. Nonresident License

Nonresident agents can obtain a license to sell insurance in Georgia if they meet the state's requirements and hold a valid license in their home state.

6. Counselor License

Counselors provide advice and information about insurance products but do not sell insurance themselves. They must obtain a separate license to practice.

7. Adjuster License

Adjusters investigate and settle insurance claims. They must be licensed to perform these duties and comply with state regulations.

8. Surplus Lines Broker

Surplus lines brokers arrange insurance coverage for risks that cannot be insured through standard markets. They must obtain a specific license to operate in this capacity.

D. Unfair Trade Practices

1. Rebating

Overview: Rebating involves offering an insured or prospective insured something of value as an inducement to purchase or renew an insurance policy.

Example: An agent offers a cashback reward to a client who purchases a new insurance policy.

2. Defamation

Overview: Defamation involves making false statements about an individual or entity that can harm their reputation.

Example: An insurance company falsely accuses a policyholder of fraud in a public statement, damaging their reputation.

3. Unfair Discrimination

Overview: Unfair discrimination occurs when an insurer treats individuals or groups differently without a valid reason based on factors like race, religion, or gender.

Example: An insurer charges higher premiums to policyholders of a certain ethnicity without any actuarial justification.

4. Misrepresentation

Overview: Misrepresentation involves providing false or misleading information about an insurance policy or its terms.

Example: An agent tells a client that a policy covers flood damage when it actually does not.

5. Controlled Business

Overview: Controlled business refers to insurance written on the agent's own life, property, or interests, which can lead to conflicts of interest.

Example: An agent sells a life insurance policy to themselves or a close family member.

6. Advertising

Overview: Unfair advertising practices involve misleading or deceptive advertisements about insurance products.

Example: An insurer advertises a policy as having "no exclusions" when, in reality, there are several important exclusions.

7. Coercion

Overview: Coercion involves using force or intimidation to persuade someone to purchase an insurance policy.

Example: An agent threatens to cancel a client's existing policy unless they buy a new, more expensive policy.

8. Commingling

Overview: Commingling refers to mixing an insured's funds with the agent's or insurer's funds, which can lead to misuse or misappropriation.

Example: An agent deposits client premiums into their personal account instead of the insurer's account.

9. Fiduciary Responsibility

Overview: Fiduciary responsibility involves acting in the best interest of the client, including handling their funds and information with care and integrity.

Example: An agent uses a client's confidential information to benefit another client without consent.

10. Sharing Commissions

Overview: Sharing commissions involves an agent paying a portion of their commission to someone who is not licensed to sell insurance.

Example: An agent gives a portion of their commission to a friend who referred a client, without the friend being a licensed agent.

11. Additional Fees

Overview: Charging unauthorized or hidden fees to policyholders is considered an unfair practice.

Example: An insurer adds undisclosed fees to a policyholder's bill without their knowledge or consent.

12. Unfair Claims Practices

Overview: Unfair claims practices involve improper handling of claims, such as delaying payment or denying valid claims without justification.

Example: An insurer repeatedly delays processing a legitimate claim without providing a valid reason.

13. Fraud

Overview: Fraud involves intentional deception for financial gain, such as falsifying claims or policy applications.

Example: An insured submits a claim for a car accident that never occurred, providing fake receipts and witness statements.

These unfair trade practices are prohibited to protect consumers and ensure fair treatment in the insurance industry.

VIII. Georgia Rules and Codes Pertinent to Property & Casualty Insurance

A. Cancellation and Nonrenewal of Policies

Overview: These rules outline the conditions and procedures for canceling or not renewing insurance policies, ensuring that policyholders are treated fairly and given adequate notice.

Example: An insurer must provide a 30-day notice before canceling a homeowner's policy for non-payment of premiums.

Reference: [O.C.G.A. § 120-2-53-.01 through .06; § 33-24-44 through 47]

B. Regulation of Rates

Overview: These regulations govern how insurance rates are determined and ensure they are fair, adequate, and not discriminatory.

Example: An insurer must file its proposed rates with the Georgia Insurance Department for approval before they can be used.

Reference: [O.C.G.A. § 33-9-1 through 44]

C. Binders

Overview: Binders are temporary insurance contracts that provide coverage until a formal policy is issued.

Example: An agent issues a binder for a new homeowner's policy, providing immediate coverage until the policy documents are finalized.

Reference: [O.C.G.A. § 33-24-33]

D. Georgia Insurer Solvency Pool

Overview: This pool provides a mechanism for ensuring that insurers remain solvent and can meet their obligations to policyholders.

Example: If an insurer becomes insolvent, the Georgia Insurer Solvency Pool steps in to cover outstanding claims.

Reference: [O.C.G.A. § 33-36-1 through 12]

IX. Georgia Rules and Codes Pertinent to Property Insurance Only

A. FAIR Plan

Overview: The FAIR (Fair Access to Insurance Requirements) Plan provides property insurance to those who cannot obtain coverage in the standard market.

Example: A homeowner who has been denied coverage due to a high-risk property can obtain insurance through the FAIR Plan.

Reference: [O.C.G.A. § 33-33-1 through 8]

X. Georgia Rules and Codes Pertinent to Casualty Insurance Only

A. Auto

1. Defensive Driving

Programs and incentives for defensive driving courses to reduce accidents and improve road safety.

Example: An insurer offers discounts on auto insurance premiums to policyholders who complete a defensive driving course.

Reference: [O.C.G.A. § 33-9-42]

2. **Uninsured Motorists Coverage Overview**

This coverage protects policyholders in the event they are involved in an accident with an uninsured driver.

Example: A policyholder's uninsured motorist coverage pays for damages when they are hit by a driver without insurance.

Reference: [O.C.G.A. § 33-7-11]

3. **Financial Responsibility Law Overview**

Laws requiring drivers to have insurance or other financial responsibility to cover damages in case of an accident. **Example:** A driver must show proof of insurance when registering their vehicle or after being involved in an accident.

Reference: [O.C.G.A. § 40-9-1 through 12; § 40-9-80 through 8; § 33-34-4]

4. **Georgia Automobile Insurance Plan/Assigned Risk Overview**

This plan provides auto insurance to high-risk drivers who cannot obtain coverage in the standard market.

Example: A driver with multiple traffic violations is assigned to an insurer through the Georgia Automobile Insurance Plan.

Reference: [O.C.G.A. § 120-2-14-.02 through .17; § 40-9-100]

B. Workers Compensation Law

Overview: These laws ensure that employees who are injured on the job receive compensation for medical expenses and lost wages.

Example: An employee who is injured at work receives medical treatment and wage replacement through their employer's workers compensation insurance.

Reference: [O.C.G.A. § 120-2-37-.01 through .09; § 34-9-133]

THAT'S IT! You finished the course.

Want to learn even more?

I've included extras such as:

- **What You Need to Memorize to Pass on the First Try!**
- **Additional Practice Quizzes**
- **Quizizz Review**
- **Summary of Georgia State Law, Rules and Regulations**

What You Need to Memorize to Pass on the First Try!

Types of Policies

Property

The land your house sits on is not insurable.

On a DP-1 under other coverages, the peril of removal is all-risk.

On a DP-1, water damage resulting from putting out a fire is covered.

The basic dwelling form DP-1 is a named or specified peril policy.

On the dwelling broad form DP-2 building structures (Coverages A and B) are written with *an 80% coinsurance requirement.*

Other structures coverage covering a detached garage excludes commercial business risks.

On a dwelling policy, other structures coverage will apply to a structure rented out as a private garage.

An example of an 'other structure' would be a detached tool shed.

A rain or dust loss would only be covered if an opening in the dwelling roof or walls was first created by wind or another covered cause of loss.

The DP 1 basic form does not provide additional living expenses under coverage D. Only fair rental value is provided.

Inflation guard, also known as the 'automatic increase endorsement,' must be added to a DP policy by endorsement.

The main difference between the various DP (dwelling property) forms is the property perils insured against.

When a dwelling is covered by more than one policy, losses are shared pro-rata under the other insurance *(or* pro-rata liability) clause.

DP policies contain general exclusions for damage due to war, nuclear hazard, and flood but not

wind.

An insured purchased a dwelling policy with a *$20,000 coverage* A limit and a *4% automatic increase* in insurance endorsement on January 1. If the insured has a claim on July 1 what is the policy limit? *$20,400.* This endorsement will increase the coverage A limits *4% per year* and will apply on an accrued basis throughout the year if a claim occurs.

Dwelling property policies do not cover breakage of glass *after 60 days vacancy.*

Dwelling property policies do not cover freezing of plumbing unless the heat was left on.

On a DP-2 broad form, Coverage B (other structures) is in addition to other coverage limits.

Dwelling property (DP) policies do not cover personal liability, although it can be added by adding an endorsement known as a personal liability supplement for an additional premium charge.

To have replacement cost coverage on a dwelling broad form policy (DP-2), the dwelling must be insured at least *80% to value, not 100%.*

Personal injury liability for false arrest, libel, slander, defamation, and invasion of privacy is not automatically covered on an HO but can be added by endorsement for an additional premium.

On an H0-6, contents coverage is named perils (broad form).

All HO policies cover theft of contents and damage done by burglars.

Coinsurance requirements on an HO are based upon the present replacement cost.

On an HO, debris removal is covered up to *5% in addition to limits.*

On a valued policy, it is not necessary to determine the ACV or the depreciation.

A liability policy will not pay the cost of defense on an excluded claim.

Medical coverage on an HO is no fault and does not require any negligence.

Proof of loss does not have to contain the names of everyone in the household.

HO liability covers bodily injury to a third party.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

A 'first-party claim' is presented by you to your insurer when your house bums down.

A mortgagee does not have to accept a binder for insurance upon renewal.

An agreement between the insured and insurer to determine the value of the property in advance is known as 'agreed amount' insurance and is often referred to as a valued policy.

If the insured dies, their policy rights are transferred to their authorized representative.

Coverage B, other structures in the homeowners and dwelling policies does not include attached garages.

In the H0-3 special form policy, theft of personal property of a resident employee is covered.

The homeowner's policy does not cover theft of animals, birds or fish.

The scheduled personal property endorsement is used to insure personal property with high values such as furs, antiques, and jewelry.

Medical payments in homeowner's policies never apply to regular members of the household.

In homeowners and personal automobile policies, expenses related to medical payments must be submitted to the insurance company *within three years* of the date of loss.

Section II of an HO policy (the liability section) contains a condition known as 'severability,' which states that coverage applies separately to each insured, but will not increase the limits of liability for any one occurrence.

All HO policies exclude coverage for flood.

Personal injury liability does not cover bodily injury it covers defamation, libel and slander.

On an HO policy, an accident that results in bodily injury or property damage is defined as an 'occurrence.'

An HO policy will provide coverage for contents anywhere in the world, including theft.

Medical coverage on an HO will cover charges for medical, surgical, x-ray, dental, ambulance, hospital, nursing, prosthetic devices and funeral services.

The bankruptcy of an insured does not relieve the insurer of their obligations under the policy.

On Section I (property) of an HO, the conditions section states that an insured must submit a signed, sworn proof of loss stating the time and cause of the loss along with an inventory of any damaged or stolen personal property.

On an HO, lawsuits may be filed by the insured against the insurer up to a *maximum of 12 months* after a loss.

Under Section II (liability) of an HO, loss assessments made against an insured by a property owners association (POA) as a result of bodily injury are *covered up to $1,000,* but not assessments made by governmental bodies.

On an HO policy, Section II (liability) provides additional coverage for damage to the property of others *up to $1,000 per occurrence.*

An HO policy will not cover the property of a boarder (renter), but will cover the property of a guest or residence employee.

An unendorsed HO policy will not cover damages resulting from off premises power failure.

An HO policy written on a dwelling under the course of construction will not cover theft.

Section II (liability) of an HO will cover the insured's use of a golf cart on a golf course.

Claims resulting from the enforcement of an ordinance or law are not covered by most property policies, although limited coverage is provided as an additional coverage on an HO policy.

On an HO, an insured may make a payment to an injured party under first aid expenses.

On an HO, the insurer's duty to defend a lawsuit is stated in the insuring agreement.

The most an HO policy will pay under the liability section is known as the limit of liability.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

An H0-8 excludes damage due to flood (all HO policies do).

On an HO policy, cemetery plots of the insured are considered to be an insured location.

Additional coverages on an HO policy (such as for trees, shrubs and plants) are in addition to limits.

The liability coverage provided by an HO is called 'premises liability.'

All HO policies provide coverage related to credit card losses *up to $500.*

A person who you hire to maintain your premises, including purchasing groceries, is referred to as a 'residence employee.'

All HO policies are package policies combining property and liability coverages.

HO forms do not cover landslide or mudslides.

The H0-8 was created specifically for older homes.

If you rent your garage to a friend who uses it to store mercantile goods there will be no coverage under your fire insurance policy.

Farm risks are not covered on DP or HO forms.

Part I of a package policy is the property section and has a deductible.

Part II of a package policy is the liability section and has no deductible.

Personal liability and medical coverage on an HO cover the insured's activities both on and off the premises.

'Loss of use' on an HO covers only additional living expenses.

An HO excludes BI and PD arising out of the loading or unloading of a motor vehicle.

Damage due to rain is not covered on a property policy unless the roof or wall was first damaged by wind or hail, allowing the rain to enter.

Property policies do not cover damage to motorized vehicles, other than those used to maintain the premises (such as riding lawn mowers).

Dwelling fire and HO policies do not cover the insured's animals, birds, or fish. An HO policy covers your contents in full while moving, for *up to 30 days.*

Coverage C on an unendorsed HO policy will cover personal property of others while on the insured's residence premises.

'Fine arts floaters' are valued and require no claims adjustment after a loss.

Dwelling fire and HO policies both cover damage to trees, shrubs, and plants, *up to $500 each.*

The dwelling 'rented to others endorsement' on an HO extends both personal liability and medical coverage to a rental dwelling owned by the insured.

An H0-6 (unit-owners policy) does not cover common area buildings.

An H0-2 is named peril on both the dwelling and contents.

An H0-3 is all-risk on the dwelling, but named peril on the contents.

The insurer's duty to defend a lawsuit on an HO policy ends when the amount paid out for damages equals the limit of liability.

Coverage C on an HO policy will not cover property of a roommate, boarder or other tenant unless related to the insured.

The definition of an insured under an HO includes residents of your household who are relatives, or *any other person under age 21 who is in your care.*

At the insured's option, recovered property will be returned to the insured or retained by the insurer.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

If the damaged property is returned, the loss payment must be adjusted.

A fine arts floater will provide automatic coverage for newly acquired fine art/or *90 days.*

In case of a loss to a 'pair or set,' the insurer may elect to repair or replace the set to its value before the loss, or pay the difference in value before and after the loss. The math would be to take the value of the full set minus the value of what is remaining.

Liability on an HO covers outboard watercraft with *25 total horsepower or less automatically.*

Property policies issued to tenants to cover contents extend coverage to losses caused by a covered peril to improvements, alterations and additions made to the described location at the tenant's expense.

The minimum deductible found in an *earthquake policy is $250.* Generally the deductible on earthquake coverage is a percentage of the policy limit.

Medical payments contained in insurance policies are paid on a per person basis, subject to the limit of liability shown on the declaration.

On a DP or HO policy, to have replacement cost coverage, the insured *must carry a policy limit of at least 80%* of the dwelling's current replacement value, not counting the land.

After *60 days of vacancy,* an HO policy will not provide coverage for vandalism.

Claims resulting from the enforcement of an ordinance or law are not covered by most property policies, although limited coverage is provided as an additional coverage on an HO policy.

On an HO, a policy will provide both liability and medical coverage if your friend is injured helping you install new carpeting.

On an HO, liability coverage does not extend to a location where you are temporarily conducting your business.

A scheduled personal property floater provides coverage on an ACV basis.

Your HO policy does not cover your garage that you rent to another to conduct a wood working business.

After a loss, if the cost of reconstructing a home exceeds its market value, the insurer will consider it to be a 'constructive total loss.'

If the insurer cancels an HO policy, they must send advance written notice to both the mortgage company and the named insured.

An HO policy will not pay the cost of defense on an excluded claim.

Property policies do not cover sewer backup.

NFIP first-tier flood insurance (emergency program) is *only available up to $35,000.*

NFIP flood insurance does not cover sewer backup or seepage through walls.

Flood insurance is sold by the government and by participating private insurers, but claims are paid by the federal government.

The maximum coverage permitted under the regular NFIP program is *$250,000 for a single-family home.*

The FIA (Federal Insurance Administration) sets flood insurance rates. To qualify for NFIP, a community must cooperate with the FIA.

'Flood' is defined as the temporary inundation of normally dry land.

Flood insurance will not cover wharves, piers or docks.

If an insured has a boat owner's policy with liability and a personal umbrella policy, the liability limits on the boat policy would be primary.

To be eligible for federal flood insurance, the community must participate in the NFIP.

The NFIP does not cover autos, outdoor furniture or furniture in the basement.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

Casualty

There is no coverage on a PAP for a mechanic who is injured while working on your car. He would be covered by workers' compensation.

Cost of defense is not included in the supplementary payments section of a PAP. It is in the insuring agreement, although it is in addition to limits.

Supplementary payments on a PAP have no deductible and are in addition to limits.

Supplementary payments on a PAP include *$250 for bail bonds;* the premiums on appeal bonds, accrued interest on judgments and *$200 a day* loss of earnings for trial appearances.

Included in the definition of an uninsured motorist is a hit-and-run driver, one whose insurer has gone bankrupt, and one who does not carry the state minimum limits.

In an accident, the owner's PAP is always the primary policy; the driver's PAP, if different, is always the excess policy.

Coverage D on a PAP is called coverage for damage to your car and is optional. It is divided into collision and other than collision. Coverage Dis written on an ACV basis and has a deductible. Other than collision coverage is also known as 'comprehensive coverage.'

'Collision' coverage on the PAP covers colliding with another object, rollover and upset. Everything else is covered by other than collision coverage.

Examples of 'other than collision' coverage are flood, earthquake and theft.

Auto medical on a PAP protects the insured and passengers in the car. It is an optional coverage. It is not a supplementary payment, and it is no-fault.

Towing and labor is an optional coverage on the PAP and costs extra.

Transportation expenses on a PAP is automatically included if you carry Part D (physical

damage) coverage. There is no deductible.

On the PAP, exclusions under other than collision include wear and tear, freezing and mechanical breakdown.

The PAP does not cover autos used as taxis or livery, but carpools are covered.

While PD liability on a PAP excludes damage to your own property, damage to your own garage is covered by your HO if you run in to it.

The Auto Assigned Risk Plan provides a method for those who have been rejected in the normal market to obtain coverage.

All authorized insurers selling auto insurance must participate in the Auto Assigned Risk Plan.

The personal auto coverage form will provide coverage for radios and tape decks if they are permanently installed in the dash.

Supplementary payments under a PAP do not cover the insured's loss of earnings except when the insured is attending a hearing or trial at the insurer's request. The insured's injuries are not covered.

Your own PAP will not cover you driving a non-owned auto furnished for your regular use.

Insureds purchase uninsured motorist coverage because of their concern of being in an auto accident with someone who has no insurance and is at-fault.

An insured purchases underinsured motorist coverage because of their concern of being in an auto accident with someone who has inadequate limits of liability and is at-fault.

In the personal auto policy, hitting a deer is an example of 'other than collision.'

The optional coverage limit for towing and labor pays on a per event/occurrence basis.

The medical payment section of the personal automobile policy pays necessary medical and funeral expenses caused by an accident and sustained by an insured.

The medical payments coverage found in the personal automobile policy will not pay for lost wages.

Hitting a pole with an insured automobile would be an example of a 'collision.'

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

Under Part D in the personal automobile policy, transportation expenses are included for renting a substitute vehicle subject to *a per diem of $20 for 30 days ($600 maximum)* as a result of a covered loss.

A parking lot attendant is not covered on your PAP while parking your car.

A covered auto on a PAP includes small pickup trucks but not snowmobiles.

If a bird hits your windshield, the windshield is covered under other than collision on a PAP.

A PAP does not provide coverage in Mexico.

An uninsured motorist does not include someone driving with the required surety bond.

A third-party claim is presented by the claimant to your insurer when you run over someone with your car.

Under UM, if you are hit by a hit-and-run driver, you must notify the police.

A PAP policy will cover damage to a garage you rent caused by a car driven by you.

Your PAP does not cover your own property in transit.

Auto medical covers you and your passengers, but not pedestrians you injure.

If an auto insurer is going to use aftermarket parts for repairs, it must be stated in the estimate or appraisal.

If you drive a company car furnished for your regular use your employer will not be covered under your PAP.

A PAP will cover small pick-up trucks, even if they are used for farming or ranching, but will not cover motorcycles, dump trucks or farm implements driven on the highway.

Flood damage is covered under a PAP, but not on property policies.

A PAP will not provide coverage for a separated spouse, since they no longer reside with the named insured.

On a PAP, an at-fault driver's injuries would be covered by medical.

'Surplus lines' coverage is written by various unauthorized companies, not just Lloyds of London.

A 'personal umbrella liability' policy will pay on an excess basis, only after a primary policy has already paid.

An 'excess limits' policy, such as an umbrella, is one written over and above the primary liability policy's limits of insurance.

Umbrella (excess) policies contain a 'retention requirement' that is like a deductible and must be paid by the insured in the event of a claim.

Umbrella policies are not written on standardized industry forms.

On a personal umbrella policy, the 'retained limit' is defined as the policy limits of the primary policies.

A 'claims made liability' policy requires that the claim occur after the retroactive date and be turned in during the policy period or within the extended reporting period.

An 'occurrence basis liability' policy covers claims that occur in the policy period, even if turned in after the expiration date.

'Burglary' is a crime against property, using forced entry or exit.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

What You Need to Memorize to Pass on the First Try!

Insurance Terms and Related Concepts

PROPERTY

A peril is a cause of loss.

Wind and fire are examples of perils.

A named peril policy covers the peril if it is listed in the policy.

An all-risk policy covers a peril only if it is not excluded.

Your house burning down is an example of a direct loss.

The additional expenses incurred to live in a rental property after your house burned down is an example of an indirect loss.

The proximate cause is the beginning of the chain of events that has a resulting loss.

The proximate loss would be the end of the chain of events.

There is a deductible on every property claim.

The deductible makes insurance more affordable and eliminates small claims.

The most the policy will pay is found in the policy limits of liability.

Cancellation occurs mid-term and will require that a refund be made to the insured.

If the insured cancels the policy, the refund owed is short-rate.

A short-rate refund means that the insurer gets to keep a little extra of the unearned premium as a penalty.

When the insurer cancels the policy, the refund owed is pro-rata.

If a policy is non-renewed, there is no refund owed.

The coinsurance clause on a personal lines policy *is the 80% clause.*

The coinsurance clause has to do with having replacement cost coverage and partial losses paid in full.

If the insured does not carry adequate limits the insurer will impose a coinsurance penalty, or pay the claim on an actual cash value basis. The insurer has to do whichever of these is better for the client.

Replacement cost minus depreciation is actual cash value. Another way to say the same thing: Current value minus depreciation is actual cash value. The test will say it either way. Make sure you know both definitions. Current value and replacement cost are one and the same.

Contents are always ACV on the test.

Beginning with the DP-2 the dwelling is covered at replacement cost.

If a claim is paid in full the salvage belongs to the insurer.

If the insured chooses to keep the salvage the insurer will pay a lesser claim amount.

If you own an animal you are held strictly liable (absolute liability) for the animal's actions.

To indemnify means “to pay”. The purpose of insurance is to restore you financially to where you were prior to the loss.

It is the principle of indemnity that says if your $200,000 house bums down you will not collect

more than $200,000.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

Negligence is a tort, a civil wrong; it is grounds for a lawsuit.

Negligence is the failure to act as a reasonable person would in the same set of circumstances.

A binder may be oral or written.

A binder provides coverage until the policy is issued.

A binder includes all coverages provided by the policy.

An endorsement is added to a policy to modify its terms.

The Extended Coverage Endorsement is added to the Standard Fire Policy to create the **DP-1.**

Medical payments coverage is no-fault.

Medical payments coverage is designed to prevent lawsuits.

On a homeowner's policy medical payments coverage is to others.

A person who takes property into the bathroom of a store and then breaks out after hours has committed a burglary.

Burglary requires signs of forced entry or exit.

A robbery is the act of stealing from a person under the threat of bodily harm.

Theft is any act of stealing.

Mysterious disappearance is defined as property gone with no apparent explanation; for example, if your son's bicycle is missing from the garage.

Homeowner's policies cover mysterious disappearance.

A hazard is something that increases the risk.

Storing an oily rag by the furnace is a physical hazard.

A person with a bad credit score is a moral hazard.

A careless person is a morale hazard.

In order to have coverage on a property policy insurable interest must exist at time of loss.

Risk is uncertainty of loss.

Investing in the stock market is speculative risk meaning you could lose or gain. You cannot insure speculative risk.

You can insure pure risk.

Pure risk means there is no chance of gain.

Insurance is a transfer of risk from the insured to the insurer.

After 60 days of vacancy, an HO policy will not provide coverage for vandalism.

On a Standard Fire Policy *after 60 days of vacancy or unoccupancy,* all coverage is suspended.

A scheduled personal property floater provides coverage on an ACV basis.

On a valued policy (stated value) there is no deduction for depreciation.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

CASUALTY

Negligence is a tort, a civil wrong; it is grounds for a lawsuit.

Negligence is the failure to act as a reasonable person would in the same set of circumstances.

A binder may be oral or written.

A binder provides coverage until the policy is issued.

A binder includes all coverages provided by the policy.

An occurrence happens over a period of time.

An accident is something that happens due to lack of foresight.

A hazard is something that increases the risk.

Liability covers BI and **PD** to others for which an insured is proven to be negligent.

Storing an oily rag by the furnace is a physical hazard.

A person with a bad credit score is a moral hazard.

A careless person is a morale hazard.

The law of large numbers is used to predict the likelihood of loss.

A certificate of insurance does include the named insured, insurer, policy limits, effective date and time and what the policy coverage is for.

The principle of indemnity governs property and casualty policies. It states that the purpose of the policy is to restore the insured financially to where they were prior to their loss.

Risk is uncertainty of loss.

Investing in the stock market is speculative risk meaning you could lose or gain. You cannot insure speculative risk.

You can insure pure risk.

Pure risk means there is no chance of gain.

Insurance is a transfer of risk from the insured to the insurer.

Concealment is an omission of a material fact.

A representation is a substantial truth.

A warranty is a literal truth.

The Fair Credit Reporting Act requires both pre-notification and post-notification.

An endorsement is added to the policy to modify its terms.

Actual cash value is replacement cost minus depreciation.

Insurable interest must exist on a casualty policy at time of loss in order for the policy to provide coverage.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

What You Need to Memorize to Pass on the First Try!

Policy Provisions and Contract Law

PROPERTY

The four parts of a policy may be remembered by the acronym D-I-C-E (declarations, insuring agreement, conditions, and exclusions).

The declarations list the named insured, policy limits, and premium and policy period.

The insuring agreement describes the coverages provided.

The conditions list the obligations of both parties; the insurer and the insured.

The exclusions list the perils that are not covered.

Dwelling property policies do not cover breakage of glass *after 60 days of vacancy.*

The limits of liability are found on the declarations page of the policy.

The cancellation provisions are found in the conditions section of the policy.

To have replacement cost coverage on a dwelling broad form policy (DP-2), the dwelling must be insured at least *80% of replacement cost, not 100%.*

Personal injury liability does not cover bodily injury; it covers defamation, libel, and slander.

On an HO policy, an accident that results in bodily injury or property damage is defined as an occurrence.

The most an HO policy will pay under the liability section is known as the limit of liability.

To determine who is an insured on an HO policy, read the definitions.

On dwelling fire and HO policies, the *required coinsurance percentage is 80%.*

The definition of an insured under an HO includes residents of your household who are relatives, or *any other person under age 21 who is in your care.*

The insurer has the right to sue the negligent third party for damages paid to you under the concept of subrogation.

The four parts of a legal contract can be remembered with the acronym of C-0-A-L.

Consideration consists of the first premium paid, the answers to the questions on the application and the applicant's signature.

Consideration is an exchange of values.

If the lender is not sent notice of cancellation, the fire insurance policy lapses, and then the

property bums down, the lender (mortgagee) has protection in the amount owed on the loan.

In an appraisal situation, both parties pay for one and a half persons.

The parties involved in an appraisal are the appraiser, appraiser, and an umpire.

An assignment is never valid unless agreed to by the insurer.

The insured must promptly tell the insurer about a claim (notice of claim).

A person must be at *minimum age 18* to enter into a legal contract.

A representation is a substantial truth.

A warranty is a literal truth.

A warranty is something you promise is there today and will be there tomorrow (like a burglar alarm or sprinkler system in the ceiling).

The Gramm-Leach-Bliley Act requires that a customer be given out a privacy notice at the time the customer relationship is initially established and thereafter annually.

The failure to disclose a material fact is called concealment, and if discovered will void the policy.

The Terrorism Risk Insurance Act (TRIA) applies to commercial policies only.

The insurer has the right to enhance coverage at any time, so long as they do not charge the client more for the enhancements, under the concept of liberalization.

A stock insurer is owned by the stockholders.

A mutual insurer is owned by the policyholders.

A mutual insurer issues participating policies. You may project a dividend on a participating policy.

You may project a dividend on a participating policy, since, if one is paid, it is paid to the policyholder.

Dividends may never be guaranteed.

Dividends may not be projected on a non-participating policy (issued by a stock insurer).

The right to salvage belongs to both parties.

If the applicant misstates a material fact on the application, this will have the effect of voiding the policy if/when discovered by the insurer.

The insured does not have to disclose all facts, just all material facts.

The Fair Credit Reporting Act requires the insurer to give the insured pre-notification prior to pulling an applicant's credit report.

If an applicant is denied coverage due in part to their credit report, the applicant must be told which consumer reporting agency was used.

Anytime a consumer has been denied coverage due in part to credit, they may now get a copy of their credit report for free from the consumer reporting agency.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

CASUALTY

The four parts of a policy may be remembered by the acronym D-I-C-E (declarations, insuring agreement, conditions, and exclusions).

The declarations list the named insured, policy limits, and premium and policy period.

The insuring agreement describes the coverages provided.

The conditions list the obligations of both parties, the insurer and the insured.

The exclusions list the perils that are not covered.

Dwelling property policies do not cover breakage of glass after *60 days vacancy.*

The limits of liability are found on the declaration page of the policy.

The cancellation provisions are found in the conditions section of the policy.

Personal injury liability does not cover bodily injury it covers defamation, libel and slander.

To determine who is an insured on a PAP policy, read the definitions.

The insurer has the right to sue the negligent third party for damages paid to you under the concept of subrogation.

The four parts of a contract can be remembered with the acronym of C-0-A-L.

Consideration consists of the first premium paid, the answers to the questions on the application and the applicant's signature.

Consideration is an exchange of values.

In an appraisal situation, both parties pay for one and a half persons.

The parties involved in an appraisal are the appraiser, appraiser, and an umpire.

An assignment is never valid unless agreed to by the insurer.

The insured must promptly tell the insurer about a claim (notice of claim).

A person must be *at minimum age 18* to enter into a legal contract.

A representation is a substantial truth.

A warranty is a literal truth.

A warranty is something you promise is there today and will be there tomorrow (like a burglar alarm or sprinkler system in the ceiling).

A surplus lines company underwrites high risk policies.

A surplus lines company is allowed to do business in this state without a certificate of authority, we call them non-admitted.

It is perfectly legal to sell insurance for a non-admitted insurer.

A domestic insurer has their home office in this state.

A foreign insurer has their home office in another state.

An alien insurer has their home office in another country.

All insurers (domestic, foreign and alien) must be admitted to do business in this state.

We sometimes call an admitted insurer authorized to do business in this state.

Professional liability policies may not be settled by the insurer without first getting consent from the insured.

If the insurer does not believe the liability policy provides coverage and the insured believes that it should then the claim will go to arbitration.

In arbitration each party pays for one and a half persons involved.

In arbitration there are three arbitrators.

The other insurance clause is also known as the pro-rata liability clause.

Pro-rata does not mean equal, it means proportionate.

The failure to disclose a material fact is called concealment, and if discovered will void the policy.

The Terrorism Risk Insurance Act (TRIA) applies to commercial policies only.

Supplementary payments on a PAP do not include cost of defense.

On a PAP cost of defense is found in the insuring agreement.

Supplementary payments on a PAP include loss of earnings *(up to $200 a day),* appeals bonds and interest, *and up to $250 towards bail bonds.*

It is in the definitions that you learn who is an insured on a policy.

On a PAP an insured is any permissive user of your car, with the exception of a mechanic.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

More Practice Quizzes

Personal Auto Insurance

14 questions on Personal Auto Insurance.

P&C Insurance Practice Exam

22 Questions. Great practice since you will be taking the Personal Lines Agent Exam

Principles of Insurance

This quiz reviews basic principles that provide a foundation for the insurance industry. They range from the concept of risk, to the idea that individuals and businesses can minimize losses by transferring and sharing risks, to the application of the law of large numbers. Various principles also determine why some risks of loss are insurable whereas others are not.

The Insurance Contract

A contract is a legal agreement between two or more competent parties that promises a certain performance in exchange for a certain consideration. When an insurance company agrees to pay for an insured's losses in exchange for a certain premium, the two parties have entered into a contract. Although a contract of insurance can be oral, it is usually written in the form of an insurance policy.

Insurance Transactions

A number of steps must be taken before an insurance transaction can be completed. These include making an application for insurance, underwriting the risk, and including all the steps required for forming a valid contract.

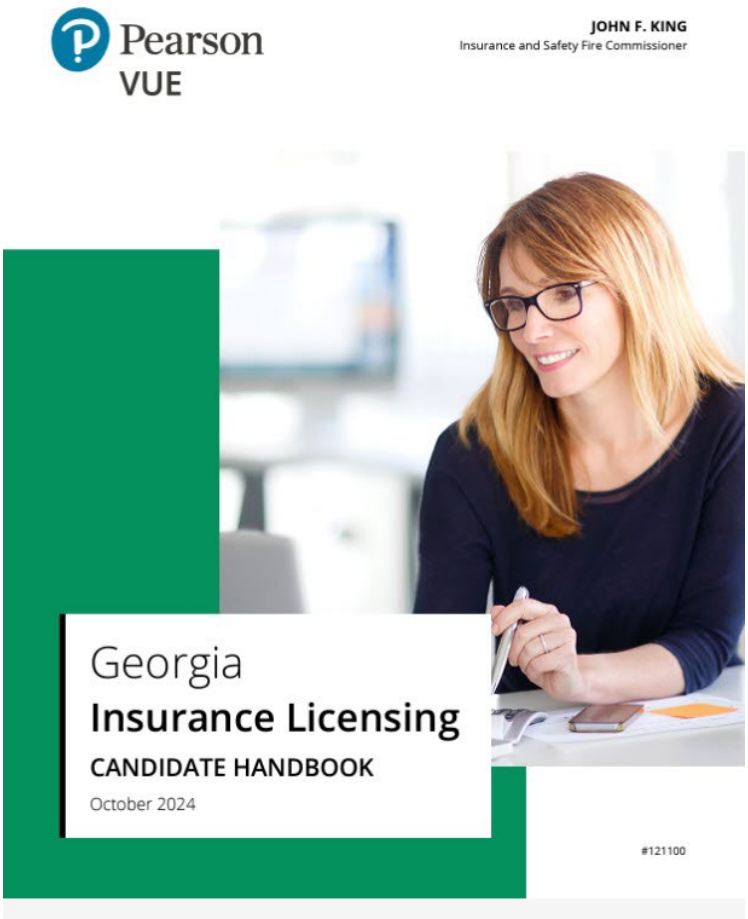
Property and Casualty Insurance License Exam Cram

252 Questions. Great practice. Don't worry about correctly answering the ones on commercial insurance since you will be taking the Personal Lines Agent Exam, but they will come in handy when you sit for the 40-hour Property & Casualty Exam.

General Insurance Exam Questions and Answers

25 Questions. Great practice. Don't worry about correctly answering the ones on commercial insurance since you will be taking the Personal Lines Agent Exam, but they will come in handy when you sit for the 40-hour Property & Casualty Exam.

Georgia Insurance Licensing Candidate Handbook



Quizizz Q&A

Question 1

What type of homeowner's insurance is specifically designed for renters?

- A) HO-2
- B) HO-3
- C) HO-4
- D) HO-5

Correct Answer: C) HO-4

Question 2

Which homeowner's insurance policy is the most common type for single-family homes in the U.S.?

- A) HO-2
- B) HO-3
- C) HO-5
- D) HO-8

Correct Answer: B) HO-3

Question 3

What does an HO-6 policy cover?

- A) Mobile homes
- B) Renters' personal property
- C) Condo owners' personal property and interior structure
- D) Older homes with unique architectural features

Correct Answer: C) Condo owners' personal property and interior structure

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Question 4

Which of the following is NOT typically covered by an HO-3 policy?

- A) Fire
- B) Flooding
- C) Theft
- D) Windstorm

Correct Answer: B) Flooding

Question 5

What is the primary difference between an HO-2 and an HO-3 policy?

- A) HO-2 covers more perils than HO-3
- B) HO-3 covers all perils except those specifically excluded
- C) HO-2 is more comprehensive than HO-5
- D) HO-3 is specifically for renters

Correct Answer: B) HO-3 covers all perils except those specifically excluded

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Question 6

Which policy is designed for mobile homes?

- A) HO-5
- B) HO-6
- C) HO-7
- D) HO-8

Correct Answer: C) HO-7

Question 7

What type of coverage does an HO-5 policy provide?

- A) Basic coverage for named perils
- B) Coverage for personal property on an open-perils basis
- C) Coverage for tenants' personal property
- D) Coverage for older homes

Correct Answer: B) Coverage for personal property on an open-perils basis

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Question 8

Which of the following is a common exclusion in an HO-3 policy?

- A) Fire
- B) Earthquakes
- C) Theft
- D) Vandalism

Correct Answer: B) Earthquakes

Question 9

What does the "loss of use" coverage in an HO-3 policy typically cover?

- A) Repairs to the dwelling
- B) Temporary living expenses while the home is being repaired
- C) Medical payments to others
- D) Liability for injuries

Correct Answer: B) Temporary living expenses while the home is being repaired

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Question 10

Which policy is specifically designed for older homes where the replacement cost exceeds the market value?

- A) HO-2
- B) HO-4
- C) HO-6
- D) HO-8

Correct Answer: D) HO-8

Question 11

What type of homeowner's insurance policy is specifically designed for renters?

- A) HO-3
- B) HO-4
- C) HO-5
- D) HO-6

Correct Answer: B) HO-4

Question 12

Which homeowner's insurance policy is most common for single-family homes?

- A) HO-2
- B) HO-3
- C) HO-5
- D) HO-8

Correct Answer: B) HO-3

Question 13

What type of coverage does an HO-5 policy provide for personal belongings?

- A) Named perils
- B) Open perils
- C) Limited perils
- D) Excluded perils

Correct Answer: B) Open perils

Question 14

Which type of homeowner's insurance is typically the cheapest and most limited?

- A) HO-2
- B) HO-3
- C) HO-5
- D) HO-8

Correct Answer: A) HO-2

Question 15

What is the primary purpose of ordinance or law coverage in a homeowner's insurance policy?

- A) To cover flood damage
- B) To cover the cost of bringing a home up to current building codes
- C) To cover personal property replacement
- D) To cover water backup damage

Correct Answer: B) To cover the cost of bringing a home up to current building codes

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Question 16

How much does guaranteed replacement cost coverage typically add to your total policy premium?

- A) 1% to 2%
- B) 3% to 4%
- C) 5% to 10%
- D) 15% to 20%

Correct Answer: C) 5% to 10%

Question 17

Which type of homeowner's insurance policy is designed for condo or co-op units?

- A) HO-3
- B) HO-4
- C) HO-5
- D) HO-6

Correct Answer: D) HO-6

Question 18

What does inflation guard coverage do in a homeowner's insurance policy?

- A) It covers flood damage
- B) It increases the dwelling coverage limit to reflect current construction costs
- C) It covers water backup damage
- D) It covers equipment breakdown

Correct Answer: B) It increases the dwelling coverage limit to reflect current construction costs

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Question 19

Which homeowner's insurance policy is preferred for high net-worth homeowner's with expensive possessions?

- A) HO-2
- B) HO-3
- C) HO-5
- D) HO-8

Correct Answer: C) HO-5

Question 20

What type of coverage does water backup coverage provide?

- A) It covers flood damage
- B) It covers water damage from sewer or sump pump backups
- C) It covers equipment breakdown
- D) It covers personal property replacement

Correct Answer: B) It covers water damage from sewer or sump pump backups

Question 21

What is covered under equipment breakdown coverage in the event of mechanical or electrical failure?

- A) Pest damage
- B) Boilers and furnaces
- C) Regular wear and tear
- D) Rust corrosion

Correct Answer: B) Boilers and furnaces

Question 22

How much does equipment breakdown coverage typically cost annually for around $50,000 in coverage per occurrence?

- A) $10 to $20
- B) $25 to $50
- C) $75 to $100
- D) $100 to $150

Correct Answer: B) $25 to $50

Question 23

Which of the following is NOT covered by service line coverage?

- A) Sewer pipes
- B) Fiber optics
- C) Regular wear and tear
- D) Maintenance issues

Correct Answer: D) Maintenance issues

Question 24

What is the typical annual cost for service line coverage for $10,000 in coverage?

- A) $10
- B) $20
- C) $30
- D) $40

Correct Answer: C) $30

Question 25

Which type of coverage helps pay for costs associated with recovering your identity but does not include monetary reimbursement?

- A) Equipment breakdown coverage
- B) Identity theft coverage
- C) Home business coverage
- D) Sinkhole coverage

Correct Answer: B) Identity theft coverage

Question 26

What is the maximum payout for home business property in a standard homeowner's insurance policy?

- A) $1,000
- B) $2,500
- C) $5,000
- D) $10,000

Correct Answer: B) $2,500

Question 27

Which of the following is automatically included in Florida home insurance policies due to the common occurrence of sinkholes?

- A) Earthquake coverage
- B) Catastrophic ground collapse coverage
- C) Flood insurance
- D) Windstorm coverage

Correct Answer: B) Catastrophic ground collapse coverage

Question 28

What type of insurance is typically sold through FEMA's National Flood Insurance Program (NFIP)?

- A) Earthquake insurance
- B) Flood insurance
- C) Sinkhole insurance
- D) Windstorm insurance

Correct Answer: B) Flood insurance

Question 29

Which of the following is NOT a property type insured by scheduled personal property coverage?

- A) Jewelry
- B) Firearms
- C) Boilers
- D) Fine art

Correct Answer: C) Boilers

Question 30

What is the typical cost for adding $15,000 in identity theft coverage to your policy annually?

- A) $10 to $20
- B) $25 to $60
- C) $75 to $100
- D) $100 to $150

Correct Answer: B) $25 to $60

Question 31

What is the primary purpose of loss assessment coverage in a home insurance policy?

- A) To cover the cost of personal belongings inside your home
- B) To cover your portion of damage to common areas in a shared community
- C) To provide liability coverage for accidents in your home
- D) To cover the cost of rebuilding your home

Correct Answer: B) To cover your portion of damage to common areas in a shared community

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Question 32

How much does a loss assessment coverage endorsement typically cost annually?

- A) $10 to $20
- B) $25 to $50
- C) $75 to $100
- D) $100 to $150

Correct Answer: B) $25 to $50

Question 33

Which of the following perils is NOT covered under an HO-3 policy?

- A) Fire or lightning
- B) Earth movement
- C) Theft
- D) Windstorm or hail

Correct Answer: B) Earth movement

Question 34

What type of insurance is HO-4 better known as?

- A) Homeowner's insurance
- B) Renters insurance
- C) Condo insurance
- D) Mobile home insurance

Correct Answer: B) Renters insurance

Question 35

Which policy provides the highest level of coverage for single-family homes?

- A) HO-2
- B) HO-3
- C) HO-5
- D) HO-8

Correct Answer: C) HO-5

Question 36

What is the main difference between HO-3 and HO-5 policies regarding personal property coverage?

- A) HO-3 covers personal property at replacement cost, while HO-5 covers it at actual cash value
- B) HO-3 covers personal property at actual cash value, while HO-5 covers it at replacement cost
- C) HO-3 does not cover personal property, while HO-5 does
- D) HO-3 covers personal property for all risks, while HO-5 covers named perils only

Correct Answer: B) HO-3 covers personal property at actual cash value, while HO-5 covers it at replacement cost

Question 37

Which type of insurance is specifically designed for mobile, manufactured, and other factory-built homes?

- A) HO-4
- B) HO-6
- C) HO-7
- D) HO-8

Correct Answer: C) HO-7

Question 38

What is a key characteristic of HO-8 insurance policies?

- A) They cover all perils except those specifically excluded
- B) They are designed for high-value properties
- C) They cover older or historic homes with ornate features
- D) They provide coverage for renters

Correct Answer: C) They cover older or historic homes with ornate features

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Question 39

Which of the following is a factor that affects the price of homeowner's insurance for older homes?

- A) The number of bedrooms
- B) The age of the roof
- C) The color of the exterior paint
- D) The type of landscaping

Correct Answer: B) The age of the roof

Question 40

What type of coverage is NOT included in HO-4 policies?

- A) Personal liability coverage
- B) Additional living expenses coverage
- C) Dwelling coverage for the physical structure
- D) Coverage for personal belongings

Correct Answer: C) Dwelling coverage for the physical structure

Question 41

Why are older homes generally more expensive to insure than newer homes?

- A) Older homes have a higher market value.
- B) The replacement cost of older homes is typically higher.
- C) Older homes are less likely to have insurance claims.
- D) Newer homes have more advanced security systems.

Correct Answer: B) The replacement cost of older homes is typically higher.

Question 42

What is a significant factor that can impact homeowner's insurance rates for older homes?

- A) The home's proximity to a fire station.
- B) The age of the home's roof and ornate features.
- C) The number of bedrooms in the home.
- D) The home's landscaping design.

Correct Answer: B) The age of the home's roof and ornate features.

Question 43

What type of wiring in older homes is more likely to cause accidental fires?

- A) Copper wiring
- B) Aluminum wiring
- C) Fiber optic wiring
- D) PVC wiring

Correct Answer: B) Aluminum wiring

Question 44

If a home is over 100 years old and difficult to insure, which organization can help find coverage?

- A) National Association of Realtors
- B) National Trust Insurance Services (NTIS)
- C) Federal Emergency Management Agency (FEMA)
- D) American Red Cross

Correct Answer: B) National Trust Insurance Services (NTIS)

Question 45

Which homeowner's insurance policy is designed for homes where the cost to rebuild is greater than the market value?

- A) HO-3 homeowner's insurance policy
- B) HO-8 homeowner's insurance policy
- C) HO-5 homeowner's insurance policy
- D) HO-2 homeowner's insurance policy

Correct Answer: B) HO-8 homeowner's insurance policy

Question 46

What additional coverage can be added to protect against sewer or drain backups in older homes?

- A) Flood insurance
- B) Water backup coverage
- C) Earthquake insurance
- D) Sinkhole coverage

Correct Answer: B) Water backup coverage

Question 47

Which type of coverage pays for damage to utility lines that run from your home to the street?

- A) Extended replacement cost coverage
- B) Service line coverage
- C) Ordinance or law coverage
- D) Scheduled personal property coverage

Correct Answer: B) Service line coverage

Question 48

What does dwelling coverage, also known as Coverage A, protect?

- A) Personal belongings like furniture and clothing
- B) Detached structures like a fence or pool
- C) The structure of your home, including foundation and walls
- D) Extra living expenses if you need to live elsewhere during repairs

Correct Answer: C) The structure of your home, including foundation and walls

Question 49

Which of the following is NOT typically covered by standard dwelling insurance?

- A) Fire and smoke damage
- B) Theft
- C) Flooding
- D) Hail and wind damage

Correct Answer: C) Flooding

Question 50

What is the purpose of ordinance or law coverage in a homeowner's insurance policy?

- A) To cover the cost of upgrading construction to meet current codes after a loss
- B) To reimburse for the actual cash value of a roof
- C) To protect against personal liability lawsuits
- D) To cover medical payments for guests injured on your property

Correct Answer: A) To cover the cost of upgrading construction to meet current codes after a loss

Question 51

What is typically not covered by a traditional homeowner's policy but is covered under "other structures" coverage?

- A) Attached garages
- B) Detached garages
- C) The main dwelling
- D) Personal belongings

Correct Answer: B) Detached garages

Question 52

Which of the following factors is NOT considered when determining the replacement cost of a home?

- A) The cost of construction and labor in your area
- B) The price you paid for the home
- C) The square footage of your home
- D) The style of house

Correct Answer: B) The price you paid for the home

Question 53

What is the primary purpose of dwelling coverage in a homeowner's insurance policy?

- A) To cover personal belongings
- B) To cover the cost of rebuilding the home
- C) To cover liability claims
- D) To cover detached structures

Correct Answer: B) To cover the cost of rebuilding the home

Question 54

Which of the following is a common endorsement that can be added to a dwelling insurance policy?

- A) Theft coverage
- B) Earthquake coverage
- C) Liability coverage
- D) Auto insurance

Correct Answer: B) Earthquake coverage

Question 55

What percentage of your total insurance cost does dwelling insurance typically account for?

- A) 50% to 60%
- B) 70% to 80%
- C) 95% to 97%
- D) 100%

Correct Answer: C) 95% to 97%

Question 56

Which of the following is NOT typically excluded from a dwelling policy?

- A) Earthquakes
- B) Flooding
- C) Fire damage
- D) Sinkholes

Correct Answer: C) Fire damage

Question 57

What does a Commercial Package Policy (CPP) typically combine?

- A) Auto and health insurance
- B) Property and liability coverage
- C) Life and disability insurance
- D) Home and auto insurance

Correct Answer: B) Property and liability coverage

Question 58

What type of insurance covers lost income and extra expenses when a business cannot operate due to a covered loss?

- A) Equipment breakdown insurance
- B) Business income insurance
- C) General liability insurance
- D) Commercial auto insurance

Correct Answer: B) Business income insurance

Question 59

What is a Personal Articles Floater (PAF) designed to cover?

- A) General liability
- B) High-value personal items
- C) Auto accidents
- D) Health expenses

Correct Answer: B) High-value personal items

Question 60

Which of the following is an example of a peril that might be covered under a Causes of Loss Form in commercial property insurance?

- A) General wear and tear
- B) Fire
- C) Employee theft
- D) Market fluctuations

Correct Answer: B) Fire

Question 61

What factors influence the cost of a Personal Articles Floater (PAF)?

- A) The age of the insured items
- B) The overall worth of the insured items, location, chosen coverage options, and insurance company policies
- C) The color of the insured items
- D) The number of insured items

Correct Answer: B) The overall worth of the insured items, location, chosen coverage options, and insurance company policies

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Question 62

Which type of coverage pays out the full agreed-upon amount of an item if a total loss occurs?

- A) All-Risk Coverage
- B) Agreed Value Coverage
- C) Replacement Cost Coverage
- D) Scheduled Items Coverage

Correct Answer: B) Agreed Value Coverage

Question 63

What is the primary purpose of the National Flood Insurance Program (NFIP)?

- A) To provide earthquake insurance
- B) To offer flood insurance to property owners, renters, and businesses
- C) To insure mobile homes
- D) To provide coverage for theft

Correct Answer: B) To offer flood insurance to property owners, renters, and businesses

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Question 64

Which of the following is NOT typically covered by mobile and manufactured home insurance?

- A) Fire and smoke
- B) Theft
- C) Earthquake
- D) Windstorms and hail

Correct Answer: C) Earthquake

Question 65

What is a key difference between mobile and modular home insurance?

- A) Modular homes are built on a permanent foundation and can be insured with a standard homeowner's insurance policy
- B) Mobile homes are more expensive to insure than modular homes
- C) Modular homes are not built in factories
- D) Mobile homes are not subject to any building codes

Correct Answer: A) Modular homes are built on a permanent foundation and can be insured with a standard homeowner's insurance policy

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Question 66

What is the significance of June 15, 1976, in the context of mobile homes?

- A) It marks the introduction of mobile home insurance
- B) It marks the date when new federal building and safety standards for manufactured homes were implemented
- C) It marks the date when mobile homes were first built
- D) It marks the date when mobile homes were banned

Correct Answer: B) It marks the date when new federal building and safety standards for manufactured homes were implemented

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Question 67

Which coverage option reimburses you the cost of buying a new item of similar type and quality without depreciation?

- A) All-Risk Coverage
- B) Agreed Value Coverage
- C) Replacement Cost Coverage
- D) Scheduled Items Coverage

Correct Answer: C) Replacement Cost Coverage

Question 68

What is a common requirement for insuring a mobile or manufactured home?

- A) It must be painted a specific color
- B) It must be placed on a concrete or cinderblock foundation
- C) It must be located in a high-risk flood area
- D) It must be less than 10 years old

Correct Answer: B) It must be placed on a concrete or cinderblock foundation

Question 69

Which of the following is a method to complement the financial protection insurance provides for valuable items?

- A) Ignoring the value of the items
- B) Storing items in a public place
- C) Investing in security measures for your home
- D) Not reassessing the value of items

Correct Answer: C) Investing in security measures for your home

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Question 70

What should you do to get started with PAF coverage?

- A) Purchase the most expensive policy available
- B) Make a list of your valuable items, assign them a value, and gather appraisals or receipts
- C) Only insure items that are less than a year old
- D) Avoid comparing quotes from different insurers

Correct Answer: B) Make a list of your valuable items, assign them a value, and gather appraisals or receipts

Question 71

What does a standard RV insurance policy cover?

- A) Only collision and theft
- B) Direct and accidental physical damage, including permanently installed accessories
- C) Only fire and smoke damage
- D) Only damage from wild animals

Correct Answer: B) Direct and accidental physical damage, including permanently installed accessories

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Question 72

Which of the following is NOT typically covered by RV insurance?

- A) Flood damage
- B) Damage from a low-hanging branch
- C) Routine maintenance costs
- D) Vandalism

Correct Answer: C) Routine maintenance costs

Question 73

What is Total Loss Replacement coverage in RV insurance?

- A) It provides a cash payout for any damage
- B) It replaces a new motor home declared a total loss within the first five years with a similar kind and quality
- C) It covers the cost of emergency lodging
- D) It covers towing and roadside assistance

Correct Answer: B) It replaces a new motor home declared a total loss within the first five years with a similar kind and quality

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Question 74

What does Campsite/Vacation Liability coverage help with?

- A) Damage to the RV while driving
- B) Liability when the motor home is parked and used as a vacation residence
- C) Theft of personal belongings
- D) Flood damage

Correct Answer: B) Liability when the motor home is parked and used as a vacation residence

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Question 75

Which of the following is a type of watercraft insurance?

- A) Homeowner's insurance
- B) Yacht insurance
- C) Auto insurance
- D) Health insurance

Correct Answer: B) Yacht insurance

Question 76

What is the dividing line between a boat and a yacht for insurance purposes according to the National Boat Owners Association?

- A) 20 feet
- B) 27 feet
- C) 30 feet
- D) 197 feet

Correct Answer: B) 27 feet

Question 77

What does Personal Watercraft Insurance typically cover?

- A) Only theft
- B) Bodily injury to another person and property damage
- C) Only towing after an accident
- D) Only damage from marine life

Correct Answer: B) Bodily injury to another person and property damage

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Question 78

What is a common deductible percentage for yacht insurance?

- A) 0.5%
- B) 1%
- C) 5%
- D) 10%

Correct Answer: B) 1%

Question 79

Which of the following is NOT typically included in yacht insurance coverage?

- A) Wear and tear
- B) Hull insurance
- C) Protection and indemnity (P&I)
- D) Longshore and harbor workers' coverage

Correct Answer: A) Wear and tear

Question 80

What is the purpose of a lay-up period in boat insurance?

- A) To cover the boat during the off-season when it isn't in the water
- B) To provide additional liability coverage
- C) To cover fuel spill liability
- D) To cover theft of personal effects

Correct Answer: A) To cover the boat during the off-season when it isn't in the water

Question 81

What is one reason why boat owners might choose to purchase watercraft insurance even if it's not mandatory?

- A) To avoid paying taxes on the boat
- B) To obtain a boat loan
- C) To increase the resale value of the boat
- D) To reduce maintenance costs

Correct Answer: B) To obtain a boat loan

Question 82

Which of the following is a reason marinas might require watercraft insurance?

- A) To ensure boats are environmentally friendly
- B) To cover potential damages or liabilities
- C) To promote boating safety courses
- D) To increase marina membership fees

Correct Answer: B) To cover potential damages or liabilities

Question 83

What is a potential financial risk of not having watercraft insurance?

- A) Increased fuel costs
- B) Higher maintenance fees
- C) Legal fees from defending against injury claims
- D) Decreased boat speed

Correct Answer: C) Legal fees from defending against injury claims

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Question 84

What should boat owners do before deciding on a watercraft insurance policy?

- A) Purchase the first policy they find
- B) Compare policies from multiple companies
- C) Only consider policies from local insurers
- D) Choose the cheapest policy available

Correct Answer: B) Compare policies from multiple companies

Question 85

Which type of insurance covers both personal and commercial risks associated with farming operations?

- A) Homeowner's Insurance
- B) Auto Insurance
- C) Farm Insurance
- D) Life Insurance

Correct Answer: C) Farm Insurance

Question 86

What is a unique risk that farm insurance covers, which is not typically covered by homeowner's insurance?

- A) Theft of personal property
- B) Crop failure due to drought
- C) Fire damage to the home
- D) Liability for a guest slipping in the kitchen

Correct Answer: B) Crop failure due to drought

Question 87

Why might a mortgage lender require windstorm insurance?

- A) To ensure the property is environmentally sustainable
- B) To protect against property damage in high-risk areas
- C) To increase the value of the property
- D) To reduce the interest rate on the mortgage

Correct Answer: B) To protect against property damage in high-risk areas

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Question 88

What is typically not covered by windstorm insurance?

- A) Roof damage from a hurricane
- B) Flood damage from storm surges
- C) Damage to personal belongings inside the home
- D) Damage to detached structures like garages

Correct Answer: B) Flood damage from storm surges

Question 89

What additional coverage must be purchased separately from windstorm insurance to cover flood damage?

- A) Auto Insurance
- B) Homeowner's Insurance
- C) Flood Insurance
- D) Life Insurance

Correct Answer: C) Flood Insurance

Question 90

What is a key step in filing a windstorm insurance claim?

- A) Waiting for a month before filing
- B) Filing the claim as soon as possible after the event
- C) Notifying the local government first
- D) Repairing the damage before filing

Correct Answer: B) Filing the claim as soon as possible after the event

Question 91

What is the primary purpose of personal lines insurance?

- A) To increase the wealth of policyholders
- B) To protect individuals from financial ruin by covering significant losses
- C) To provide investment opportunities
- D) To ensure policyholders pay the highest premiums possible

Correct Answer: B) To protect individuals from financial ruin by covering significant losses

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Question 92

Which of the following is NOT a type of personal lines insurance?

- A) Homeowner's Insurance
- B) Auto Insurance
- C) Business Liability Insurance
- D) Renters Insurance

Correct Answer: C) Business Liability Insurance

Question 93

What does the Law of Large Numbers help insurance companies to do?

- A) Increase the number of policyholders
- B) Predict the number of claims more accurately
- C) Reduce the number of claims
- D) Increase premiums

Correct Answer: B) Predict the number of claims more accurately

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Question 94

In the context of insurance, what does the Law of Large Numbers imply?

- A) The actual loss per event will equal the expected loss per event with a large number of policyholders
- B) The actual loss per event will always be higher than the expected loss
- C) The actual loss per event will always be lower than the expected loss
- D) The actual loss per event is unrelated to the expected loss

Correct Answer: A) The actual loss per event will equal the expected loss per event with a large number of policyholders

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Question 95

What is insurable interest?

- A) A financial stake in the insured item or event
- B) A type of insurance policy
- C) A method to increase insurance premiums
- D) A way to avoid paying insurance claims

Correct Answer: A) A financial stake in the insured item or event

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Question 96

Which of the following is an example of insurable interest?

- A) A person buying insurance for a stranger's car
- B) A homeowner insuring their own house
- C) A company insuring a competitor's building
- D) A person insuring a public park

Correct Answer: B) A homeowner insuring their own house

Question 97

Why is insurable interest important in insurance policies?

- A) It ensures that the policyholder has a financial incentive to cause a loss
- B) It makes the insurance policy legal and valid
- C) It allows anyone to purchase insurance for any item
- D) It increases the premiums for the policyholder

Correct Answer: B) It makes the insurance policy legal and valid

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Question 98

What is a potential problem with the Law of Large Numbers in health and fire insurance?

- A) Policyholders are dependent on each other
- B) Policyholders are independent of each other
- C) It always results in higher premiums
- D) It reduces the number of policyholders

Correct Answer: B) Policyholders are independent of each other

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Question 99

Which type of insurance is often required by law?

- A) Life Insurance
- B) Auto Liability Insurance
- C) Health Insurance
- D) Umbrella Insurance

Correct Answer: B) Auto Liability Insurance

Question 100

What does the Law of Large Numbers suggest about the average value as the number of observations increases?

- A) The average value becomes less predictable
- B) The average value gains predictive power
- C) The average value remains constant
- D) The average value decreases

Correct Answer: B) The average value gains predictive power

Question 101

What is insurable interest?

- A) The ability to profit from an insurance policy.
- B) A reasonable assumption of financial loss if a person or entity is damaged or lost.
- C) The likelihood of an insurance company making a profit.
- D) The process of underwriting an insurance policy.

Correct Answer: B) A reasonable assumption of financial loss if a person or entity is damaged or lost.

Question 102

Why is insurable interest required for insurance policies?

- A) To ensure that the policyholder can profit from the insurance.
- B) To prove that the policyholder would experience financial hardship from a loss.
- C) To allow anyone to take out insurance on any person or property.
- D) To increase the premiums for the insurance company.

Correct Answer: B) To prove that the policyholder would experience financial hardship from a loss.

Question 103

What is a moral hazard in the context of insurance?

- A) The risk of an insurance company going bankrupt.
- B) The incentive for a policyholder to cause a loss to collect insurance.
- C) The process of evaluating insurable interest.
- D) The likelihood of a natural disaster occurring.

Correct Answer: B) The incentive for a policyholder to cause a loss to collect insurance.

Question 104

Which of the following is an example of pure risk?

- A) Investing in the stock market.
- B) Starting a new business.
- C) The risk of a house fire.
- D) Buying a lottery ticket.

Correct Answer: C) The risk of a house fire.

Question 105

What distinguishes pure risk from speculative risk?

- A) Pure risk involves only the possibility of loss, while speculative risk involves the possibility of loss or gain.
- B) Pure risk is always profitable, while speculative risk is not.
- C) Speculative risk is insurable, while pure risk is not.
- D) Pure risk is a type of investment, while speculative risk is not.

Correct Answer: A) Pure risk involves only the possibility of loss, while speculative risk involves the possibility of loss or gain.

Question 106

Which of the following is NOT a category of pure risk?

- A) Personal risk
- B) Property risk
- C) Liability risk
- D) Investment risk

Correct Answer: D) Investment risk

Question 107

Why can't you take out a life insurance policy on just anybody?

- A) Because it would be too expensive.
- B) Because you need to have an insurable interest in the person.
- C) Because life insurance is only for family members.
- D) Because it is illegal to insure strangers.

Correct Answer: B) Because you need to have an insurable interest in the person.

Question 108

What is the principle of indemnity in insurance?

- A) Insurance should provide a profit to the policyholder.
- B) Insurance should compensate for a loss without rewarding or penalizing the policyholder.
- C) Insurance should cover all possible risks.
- D) Insurance should be mandatory for all individuals.

Correct Answer: B) Insurance should compensate for a loss without rewarding or penalizing the policyholder.

Question 109

Which of the following is an example of a moral hazard?

- A) A homeowner buying insurance for their own home.
- B) A person taking out life insurance on a terminally ill acquaintance without their knowledge.
- C) A business insuring its key employees.
- D) A driver purchasing car insurance.

Correct Answer: B) A person taking out life insurance on a terminally ill acquaintance without their knowledge.

Question 110

How can pure risk be mitigated?

- A) By investing in speculative ventures.
- B) By transferring the risk to an insurance company.
- C) By ignoring the risk.
- D) By increasing the potential for gain.

Correct Answer: B) By transferring the risk to an insurance company.

Question 111

What is the definition of a hazard in the context of insurance?

- A) A specific cause of loss or damage covered by an insurance policy.
- B) A condition that increases the likelihood or severity of a loss.
- C) An event for which insurance coverage is not available.
- D) The cost to replace an item minus depreciation.

Correct Answer: B) A condition that increases the likelihood or severity of a loss.

Question 112

Which of the following is an example of a moral hazard?

- A) Storing flammable materials in a home.
- B) A business owner ignoring health and safety concerns in the workplace.
- C) Smoking, which increases the chance of a fire.
- D) A rockslide threatening people standing underneath a cliff.

Correct Answer: B) A business owner ignoring health and safety concerns in the workplace.

Question 113

What is the primary difference between a peril and a hazard in the insurance industry?

- A) A peril is a condition, while a hazard is an event.
- B) A peril is a potential adverse event, while a hazard makes that event more likely.
- C) A peril is a factor that increases the likelihood of a loss, while a hazard is a specific cause of loss.
- D) A peril is a type of insurance coverage, while a hazard is a type of insurance policy.

Correct Answer: B) A peril is a potential adverse event, while a hazard makes that event more likely.

Question 114

Which of the following is considered an uninsurable peril?

- A) Fire
- B) Theft
- C) Political risk
- D) Windstorm

Correct Answer: C) Political risk

Question 115

What is an example of a direct loss?

- A) Loss of rental income due to fire damage to a rental property.
- B) Fire damage to a building.
- C) A hacker stealing key computer code.
- D) A CEO involved in a scandal damaging a company's reputation.

Correct Answer: B) Fire damage to a building.

Question 116

What does Actual Cash Value (ACV) represent in loss valuation?

- A) The original purchase price of an item.
- B) The cost to replace an item minus depreciation.
- C) The full insured value of a property.
- D) The maximum settlement possible according to the insurance policy.

Correct Answer: B) The cost to replace an item minus depreciation.

Question 117

Which of the following is an example of a physical hazard?

- A) A failure to regularly have the brakes of a car checked.
- B) A legal system encouraging people to sue for monetary gain.
- C) Frayed electrical wiring.
- D) A business owner ignoring health and safety concerns.

Correct Answer: C) Frayed electrical wiring.

Question 118

What is the definition of an actual total loss?

- A) A loss that occurs when an insured property is damaged but can be repaired.
- B) A loss that occurs when an insured property is destroyed or damaged to such an extent that it cannot be recovered or repaired.
- C) A loss that occurs when an insured property is partially damaged.
- D) A loss that occurs when an insured property is stolen.

Correct Answer: B) A loss that occurs when an insured property is destroyed or damaged to such an extent that it cannot be recovered or repaired.

Question 119

Which of the following is an example of a morale hazard?

- A) Smoking, which increases the chance of a fire.
- B) A business owner ignoring health and safety concerns.
- C) An individual being less careful about avoiding injury because they have insurance.
- D) A hacker stealing trade secrets.

Correct Answer: C) An individual being less careful about avoiding injury because they have insurance.

Question 120

What is an example of an indirect loss?

- A) Fire damage to a building.
- B) Loss of rental income due to fire damage to a rental property.
- C) A rockslide threatening people standing underneath a cliff.
- D) A CEO involved in a scandal damaging a company's reputation.

Correct Answer: B) Loss of rental income due to fire damage to a rental property.

Question 121

What is the definition of "Actual Total Loss" in the context of insurance?

- A) A situation where the property is partly damaged but repairable.
- B) A situation where the property is destroyed or damaged beyond use or salvage.
- C) A situation where the property is damaged but can be used with some repairs.
- D) A situation where the property is stolen but can be recovered.

Correct Answer: B) A situation where the property is destroyed or damaged beyond use or salvage.

Question 122

Which of the following best describes "Constructive Total Loss"?

- A) The property is completely destroyed with no chance of recovery.
- B) The property is partly damaged, but further damage is inevitable, making it unusable.
- C) The property is stolen and cannot be recovered.
- D) The property is damaged but can be repaired at a cost less than its value.

Correct Answer: B) The property is partly damaged, but further damage is inevitable, making it unusable.

Question 123

What is "Actual Cash Value" (ACV) in insurance terms?

- A) The original purchase price of the property.
- B) The depreciated value of the property at the time of loss.
- C) The cost to replace the property with a new one.
- D) The market value of the property when it was new.

Correct Answer: B) The depreciated value of the property at the time of loss.

Question 124

What does "Replacement Cost" insurance cover?

- A) The depreciated value of the property.
- B) The cost to replace the item with a new one.
- C) The cost to repair the damaged property.
- D) The original purchase price of the property.

Correct Answer: B) The cost to replace the item with a new one.

Question 125

In the context of car insurance, what does it mean when a car is "totaled"?

- A) The car is slightly damaged but still drivable.
- B) The cost to repair the car is more than its actual cash value.
- C) The car is stolen and not recovered.
- D) The car is damaged but can be repaired at a low cost.

Correct Answer: B) The cost to repair the car is more than its actual cash value.

Question 126

What is the first step to take after your car is declared a total loss?

- A) Purchase a new car immediately.
- B) File a claim with your insurance company.
- C) Negotiate with the car dealer for a new car.
- D) Sell the damaged car for parts.

Correct Answer: B) File a claim with your insurance company.

Question 127

How can you negotiate a better settlement for a totaled car?

- A) Accept the first offer from the insurance company.
- B) Provide the claims adjuster with the sticker details of your car.
- C) Ignore the insurance company's offer and buy a new car.
- D) Wait for the insurance company to increase their offer.

Correct Answer: B) Provide the claims adjuster with the sticker details of your car.

Question 128

What is a "total loss threshold" in the context of car insurance?

- A) The maximum amount an insurance company will pay for a claim.
- B) The percentage of damage at which a car is declared a total loss.
- C) The minimum amount an insurance company will pay for a claim.
- D) The percentage of the car's value that is covered by insurance.

Correct Answer: B) The percentage of damage at which a car is declared a total loss.

Question 129

What is the role of an insurance adjuster in the case of a total loss?

- A) To sell the damaged property.
- B) To determine the actual cash value of the damaged property.
- C) To repair the damaged property.
- D) To purchase a new property for the insured.

Correct Answer: B) To determine the actual cash value of the damaged property.

Question 130

What should you do if you want to get more from your total loss vehicle settlement?

- A) Accept the initial offer from the insurance company.
- B) Prepare a counteroffer based on research of your car's retail value.
- C) Wait for the insurance company to increase their offer.
- D) Sell the damaged car for parts.

Correct Answer: B) Prepare a counteroffer based on research of your car's retail value.

Question 131

What is the first step you should take if you are unhappy with your auto insurance company's payout for a total loss vehicle?

- A) Hire a lawyer
- B) Appeal the total loss
- C) Meet with an independent adjuster
- D) File a complaint with the insurance regulator

Correct Answer: B) Appeal the total loss

Question 132

Which of the following best describes the replacement cost?

- A) The cost to replace an item with a new one of similar kind and quality
- B) The current market value of an item
- C) The original purchase price of an item
- D) The depreciated value of an item

Correct Answer: A) The cost to replace an item with a new one of similar kind and quality

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Question 133

How is the actual cash value (ACV) of an item calculated?

- A) By adding depreciation to the replacement cost
- B) By subtracting depreciation from the replacement cost
- C) By multiplying the replacement cost by the item's age
- D) By dividing the replacement cost by the item's useful life

Correct Answer: B) By subtracting depreciation from the replacement cost

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Question 134

In the example provided, what is the actual cash value of a television set purchased for $3,000 five years ago, with a replacement cost of $3,500 and a useful life of 10 years?

- A) $1,500
- B) $1,750
- C) $2,000
- D) $2,500

Correct Answer: B) $1,750

Question 135

Which of the following is NOT a condition for determining fair market value?

- A) Both buyer and seller are reasonably knowledgeable about the asset
- B) Both parties are under pressure to complete the transaction quickly
- C) Buyer and seller are acting in their own best interests
- D) Each party has a reasonable period to complete the transaction

Correct Answer: B) Both parties are under pressure to complete the transaction quickly

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Question 136

What is the primary difference between fair market value and market value?

- A) Fair market value is always higher than market value
- B) Fair market value considers economic principles of free and open market activity
- C) Market value is used in legal settings, while fair market value is not
- D) Market value is determined by a single appraiser's opinion

Correct Answer: B) Fair market value considers economic principles of free and open market activity

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Question 137

Which of the following is a practical use of fair market value?

- A) Determining the original purchase price of an asset
- B) Calculating municipal property taxes
- C) Estimating the sentimental value of an item
- D) Setting the retail price of a new product

Correct Answer: B) Calculating municipal property taxes

Question 138

How can you determine the fair market value of your car?

- A) By checking the original purchase receipt
- B) By consulting the Kelley Blue Book
- C) By asking a friend for their opinion
- D) By calculating the car's depreciation

Correct Answer: B) By consulting the Kelley Blue Book

Question 139

In a divorce, how are liquid assets like stocks and bonds typically valued?

- A) According to their fair market value
- B) Based on their original purchase price
- C) According to current market prices
- D) By an independent appraiser's opinion

Correct Answer: C) According to current market prices

Question 140

What is a recoverable depreciation clause in an insurance policy?

- A) It allows the owner to claim only the depreciated value of an item
- B) It allows the owner to claim both the depreciated value and the replacement actual cash value
- C) It prevents the owner from claiming any depreciation
- D) It requires the owner to pay for depreciation out of pocket

Correct Answer: B) It allows the owner to claim both the depreciated value and the replacement actual cash value

Question 141

What is the definition of "stated/agreed value" in the context of insurance?

- A) The estimated resale value of an asset at the end of its useful life.
- B) The value of an insured item as stated by the policyholder, agreed upon by the insurer.
- C) The amount an insurance company pays for a totaled car.
- D) The cost to repair a damaged vehicle.

Correct Answer: B) The value of an insured item as stated by the policyholder, agreed upon by the insurer.

Question 142

Which of the following best describes "salvage value"?

- A) The value of a car before an accident.
- B) The cost to repair a damaged vehicle.
- C) The estimated resale value of an asset at the end of its useful life.
- D) The amount an insurance company pays for a totaled car.

Correct Answer: C) The estimated resale value of an asset at the end of its useful life.

Question 143

What is a "total loss" in car insurance terms?

- A) When the cost to repair a car is less than its actual cash value.
- B) When the cost to repair a car exceeds its actual cash value.
- C) When a car is stolen and not recovered.
- D) When a car is damaged but still drivable.

Correct Answer: B) When the cost to repair a car exceeds its actual cash value.

Question 144

What is the "total loss threshold" in New York?

- A) 50%
- B) 60%
- C) 75%
- D) 80%

Correct Answer: C) 75%

Question 145

Which type of insurance covers damage to your car in an accident with another vehicle or an object?

- A) Liability insurance
- B) Comprehensive insurance
- C) Collision insurance
- D) Gap insurance

Correct Answer: C) Collision insurance

Question 146

What is "proximate cause" in the context of insurance claims?

- A) The estimated resale value of an asset.
- B) The primary cause of an injury or damage.
- C) The cost to repair a damaged vehicle.
- D) The value of an insured item as stated by the policyholder.

Correct Answer: B) The primary cause of an injury or damage.

Question 147

If another driver was at fault in an accident, which type of insurance should cover a totaled car?

- A) Collision insurance
- B) Comprehensive insurance
- C) Property damage liability insurance
- D) Gap insurance

Correct Answer: C) Property damage liability insurance

Question 148

What is the purpose of gap insurance?

- A) To cover the cost of repairs for a damaged vehicle.
- B) To cover the gap between what the insurance company pays and what you owe on a loan or lease.
- C) To provide liability coverage for accidents.
- D) To insure the resale value of a vehicle.

Correct Answer: B) To cover the gap between what the insurance company pays and what you owe on a loan or lease.

Question 149

Which of the following is NOT a factor in determining a car's actual cash value?

- A) Year, make, and model
- B) Mileage
- C) Color of the car
- D) Overall condition

Correct Answer: C) Color of the car

Question 150

What must be proven to show a defendant should be held accountable for a personal injury?

- A) The defendant had a legal duty, failed to fulfill it, caused the injury, and the injury caused compensable damage.
- B) The defendant had a legal duty and fulfilled it.
- C) The defendant caused the injury but did not have a legal duty.
- D) The injury was caused by an unavoidable accident.

Correct Answer: A) The defendant had a legal duty, failed to fulfill it, caused the injury, and the injury caused compensable damage.

Question 151

What is another term for "actual cause" in legal terminology?

- A) Legal cause
- B) Cause in fact
- C) Foreseeable cause
- D) Substantial cause

Correct Answer: B) Cause in fact

Question 152

In the context of causation, what does the "but for" test determine?

- A) Whether the defendant's actions were the sole cause of the injury
- B) Whether the injury would have occurred without the defendant's negligence
- C) Whether the defendant could have foreseen the injury
- D) Whether the defendant's actions were a substantial factor in causing the injury

Correct Answer: B) Whether the injury would have occurred without the defendant's negligence

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Question 153

Which test examines if the defendant's actions played a significant role in causing an injury, even if not the sole cause?

- A) "But for" test
- B) Foreseeability test
- C) Substantial factor test
- D) Direct causation test

Correct Answer: C) Substantial factor test

Question 154

What does "proximate cause" refer to in legal terms?

- A) The immediate and direct cause of an accident
- B) The primary cause that set everything in motion
- C) The sole cause of an injury
- D) The cause that is most foreseeable

Correct Answer: B) The primary cause that set everything in motion

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Question 155

In the example where a car is rear-ended by a truck, causing it to hit a pedestrian, what is the proximate cause of the accident?

- A) The pedestrian's actions
- B) The car's movement into the intersection
- C) The truck's failure to stop
- D) The pedestrian's failure to look both ways

Correct Answer: C) The truck's failure to stop

Question 156

What is the role of foreseeability in determining proximate cause?

- A) It determines if the defendant's actions were the sole cause of the injury
- B) It assesses whether the consequences of the defendant's actions were predictable
- C) It evaluates if the defendant's actions were a substantial factor in causing the injury
- D) It identifies the immediate cause of the injury

Correct Answer: B) It assesses whether the consequences of the defendant's actions were predictable

Question 157

Which of the following is an example of an intervening cause that might break the direct causal chain?

- A) A driver speeding and hitting another car
- B) A contractor improperly installing a gas stove
- C) A house being hit by lightning and catching fire
- D) A pedestrian crossing the street without looking

Correct Answer: C) A house being hit by lightning and catching fire

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Question 158

In the Palsgraf v. Long Island Railroad Company case, why was the woman unable to recover damages?

- A) She was not a foreseeable victim of the employees' negligence
- B) The employees' actions were not negligent
- C) The harm was not directly caused by the employees
- D) The harm was not substantial enough

Correct Answer: A) She was not a foreseeable victim of the employees' negligence

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Question 159

What is the significance of "harm within the risk" in determining liability?

- A) It limits liability to foreseeable plaintiffs only
- B) It restricts liability to the risks associated with ordinary use
- C) It allows liability for any harm caused by the defendant
- D) It expands liability to all possible consequences of the defendant's actions

Correct Answer: B) It restricts liability to the risks associated with ordinary use

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Question 160

In car accident cases, what often determines the party responsible for a plaintiff's damages?

- A) The severity of the injuries
- B) The number of vehicles involved
- C) The establishment of proximate cause
- D) The speed of the vehicles at the time of the accident

Correct Answer: C) The establishment of proximate cause

Question 161

What is proximate cause in legal terms?

- A) The actual cause of an event
- B) A legal theory that establishes fault and legal liability
- C) The immediate cause of an event
- D) The cause that is most obvious

Correct Answer: B) A legal theory that establishes fault and legal liability

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Question 162

In a product liability case, what must a plaintiff prove to recover compensation?

- A) That the product was expensive
- B) That the product was defective or dangerous and caused their injuries
- C) That the product was popular
- D) That the product was new

Correct Answer: B) That the product was defective or dangerous and caused their injuries

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Question 163

Which of the following is an example of a situation where proximate cause might not be established?

- A) A driver speeding in clear weather
- B) A deer running in front of a car causing a collision
- C) A pedestrian jaywalking
- D) A driver stopping at a red light

Correct Answer: B) A deer running in front of a car causing a collision

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Question 164

In the context of insurance, what does a deductible refer to?

- A) The total amount an insurance company will pay
- B) The amount the insured must pay out of pocket before insurance covers the loss
- C) The premium paid for the insurance policy
- D) The amount paid by the insurance company for any claim

Correct Answer: B) The amount the insured must pay out of pocket before insurance covers the loss

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Question 165

What is the formula to determine if the coinsurance requirement is met?

- A)Value of the property×Coinsurance percentage=Minimum insurance amount requiredV alue of the property×Coinsurance percentage=Minimum insurance amount required
- B)Deductible+Repair cost=Total insurance coverageDeductible+Repair cost=Total insura nce coverage
- C)Insurance premium×Policy term=Total costInsurance premium×Policy term=Total cost
- D)Repair cost−Deductible=Amount payableRepair cost−Deductible=Amount payable

Correct
Answer: A) Value of the property×Coinsurance percentage=Minimum insurance amount require dValue of the property×Coinsurance percentage=Minimum insurance amount required

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Question 166

In a personal injury case, what must a plaintiff prove to establish proximate cause?

- A) The defendant's actions were a substantial factor in causing the injury
- B) The defendant was present at the scene
- C) The plaintiff was not at fault
- D) The injury was severe

Correct Answer: A) The defendant's actions were a substantial factor in causing the injury

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Question 167

What is the primary challenge in proving proximate cause in toxic tort claims?

- A) The cost of legal fees
- B) Establishing a pattern of similar injuries
- C) The time it takes for illnesses to develop
- D) The popularity of the product

Correct Answer: C) The time it takes for illnesses to develop

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Question 168

What does indemnity insurance cover?

- A) The full market value of a property
- B) Losses or damages up to a certain limit
- C) Only legal fees
- D) All possible future losses

Correct Answer: B) Losses or damages up to a certain limit

Question 169

In the context of insurance, what are limits of liability?

- A) The minimum amount an insurance company will pay
- B) The maximum amounts an insurance company will pay for a covered loss
- C) The total amount of premiums paid
- D) The deductible amount

Correct Answer: B) The maximum amounts an insurance company will pay for a covered loss

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Question 170

In a multi-car accident, who can be held liable?

- A) Only the driver who caused the initial collision
- B) Any party whose actions were a proximate cause of the accident
- C) Only the driver with the most expensive car
- D) The driver with the least insurance coverage

Correct Answer: B) Any party whose actions were a proximate cause of the accident

Question 171

What is an occurrence policy in insurance?

- A) A policy that covers claims only if they are filed while the policy is active.
- B) A policy that covers claims for incidents that occurred during the policy period, regardless of when the claim is filed.
- C) A policy that provides coverage for a fixed period and cannot be renewed.
- D) A policy that offers coverage only for specific types of damages.

Correct Answer: B) A policy that covers claims for incidents that occurred during the policy period, regardless of when the claim is filed.

Question 172

Which of the following is a key advantage of an occurrence policy?

- A) It is generally cheaper than claims-made policies.
- B) It offers long-term protection for incidents that occurred during the policy period.
- C) It allows for unlimited coverage without any caps.
- D) It requires claims to be filed within the policy period.

Correct Answer: B) It offers long-term protection for incidents that occurred during the policy period.

Question 173

What is the primary difference between occurrence policies and claims-made policies?

- A) Occurrence policies cover claims filed only during the policy period, while claims-made policies cover claims filed at any time.
- B) Occurrence policies cover incidents that happened during the policy period, while claims-made policies cover claims filed during the policy period.
- C) Occurrence policies are only for personal insurance, while claims-made policies are for business insurance.
- D) Occurrence policies are more expensive than claims-made policies.

Correct Answer: B) Occurrence policies cover incidents that happened during the policy period, while claims-made policies cover claims filed during the policy period.

Question 174

What is a common reason for the non-renewal of a car insurance policy?

- A) The policyholder has not filed any claims.
- B) The insurance company decides to reduce the number of policies in a specific area.
- C) The policyholder has a perfect driving record.
- D) The insurance company is expanding its business in the state.

Correct Answer: B) The insurance company decides to reduce the number of policies in a specific area.

Question 175

What does cancellation of an insurance policy mean?

- A) The policy is automatically renewed at the end of its term.
- B) The policy is terminated before its expiration date.
- C) The policyholder receives additional benefits.
- D) The policy is upgraded to a higher coverage level.

Correct Answer: B) The policy is terminated before its expiration date.

Question 176

Which of the following is NOT a method of cancellation in insurance?

- A) Pro-rata cancellation
- B) Short-rate cancellation
- C) Flat cancellation
- D) Extended cancellation

Correct Answer: D) Extended cancellation

Question 177

What is the main disadvantage of an occurrence policy?

- A) It is generally more expensive than claims-made policies.
- B) It does not cover incidents that occurred during the policy period.
- C) It requires claims to be filed within the policy period.
- D) It offers no long-term protection.

Correct Answer: A) It is generally more expensive than claims-made policies.

Question 178

What happens in a pro-rata cancellation of an insurance policy?

- A) The policyholder receives no refund of premiums.
- B) The unearned premium is returned without any penalty.
- C) The policyholder is charged a penalty for early termination.
- D) The policy is canceled on or before the start date without any charges.

Correct Answer: B) The unearned premium is returned without any penalty.

Question 179

Which of the following is a reason for the cancellation of a car insurance policy?

- A) The policyholder has a clean driving record.
- B) The policyholder commits insurance fraud.
- C) The policyholder pays premiums on time.
- D) The policyholder has no moving violations.

Correct Answer: B) The policyholder commits insurance fraud.

Question 180

What is the definition of nonrenewal in the context of insurance?

- A) The policy is automatically renewed at the end of its term.
- B) The insurance company decides not to renew a policy at the end of its term.
- C) The policyholder cancels the policy before its expiration date.
- D) The policy is upgraded to a higher coverage level.

Correct Answer: B) The insurance company decides not to renew a policy at the end of its term.

Question 181

What is a more serious consequence than non-renewal in car insurance?

- A) Policy expiration
- B) Policy cancellation
- C) Policy adjustment
- D) Policy extension

Correct Answer: B) Policy cancellation

Question 182

Which of the following is NOT a reason for car insurance cancellation?

- A) Late payments
- B) Too many accidents
- C) Providing fraudulent information
- D) Suspended driver's license

Correct Answer: B) Too many accidents

Question 183

How many days' notice must New York insurance companies give before canceling a policy due to non-payment?

- A) 10 days
- B) 15 days
- C) 20 days
- D) 30 days

Correct Answer: B) 15 days

Question 184

What is the primary difference between a vacant house and an unoccupied house according to insurance companies?

- A) The presence of utilities
- B) The presence of personal belongings
- C) The homeowner's intention to return
- D) The duration of absence

Correct Answer: C) The homeowner's intention to return

Question 185

What is a common consequence of driving uninsured?

- A) Reduced insurance premiums
- B) Increased insurance premiums
- C) No legal consequences
- D) Automatic policy renewal

Correct Answer: B) Increased insurance premiums

Question 186

What should you do if your car insurance policy is canceled or non-renewed?

- A) Wait until the policy expires
- B) Immediately seek new coverage
- C) Ignore the notice
- D) Drive without insurance

Correct Answer: B) Immediately seek new coverage

Question 187

What is a vacancy clause in homeowner's insurance?

- A) A clause that increases coverage during vacancy
- B) A clause that limits coverage during vacancy
- C) A clause that has no effect on coverage
- D) A clause that extends coverage indefinitely

Correct Answer: B) A clause that limits coverage during vacancy

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Question 188

Which of the following is a recommended action to mitigate risks during a home vacancy?

- A) Leave all utilities on
- B) Install video surveillance
- C) Remove all furniture
- D) Ignore plumbing systems

Correct Answer: B) Install video surveillance

Question 189

What happens if a house is vacant beyond the period specified in the insurance policy?

- A) The policy provides full coverage
- B) The policy provides partial coverage
- C) The policy does not cover damages
- D) The policy coverage is doubled

Correct Answer: C) The policy does not cover damages

Question 190

What is a potential consequence of a lapse in car insurance coverage?

- A) Lower insurance rates
- B) Higher insurance rates
- C) No change in insurance rates
- D) Automatic reinstatement of the policy

Correct Answer: B) Higher insurance rates

Question 191

What is the primary purpose of liability insurance?

- A) To cover the policyholder's own injuries and property damage
- B) To protect against claims resulting from injuries and damage to other people or property
- C) To provide coverage for intentional acts
- D) To insure against natural disasters

Correct Answer: B) To protect against claims resulting from injuries and damage to other people or property

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Question 192

Which type of liability insurance extends the coverage limits of homeowner’s and auto liability policies?

- A) Bodily injury liability insurance
- B) Property damage liability insurance
- C) Umbrella insurance
- D) Personal injury protection

Correct Answer: C) Umbrella insurance

Question 193

What is the definition of strict liability?

- A) Liability imposed without regard to fault or negligence
- B) Liability that holds a party responsible for damages or injuries regardless of fault or intent
- C) Liability for the actions of another party
- D) Liability for failing to exercise reasonable care

Correct Answer: B) Liability that holds a party responsible for damages or injuries regardless of fault or intent

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Question 194

Which of the following is NOT typically covered by liability insurance?

- A) Third-party bodily injury
- B) Third-party property damage
- C) The policyholder's own medical expenses in an at-fault accident
- D) Legal defense costs for covered claims

Correct Answer: C) The policyholder's own medical expenses in an at-fault accident

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Question 195

What is a binder in the context of insurance?

- A) A permanent insurance contract
- B) A temporary insurance contract providing coverage until a permanent policy is issued
- C) An addition or change to an existing insurance policy
- D) A document that provides evidence of insurance coverage

Correct Answer: B) A temporary insurance contract providing coverage until a permanent policy is issued

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Question 196

Which of the following is an example of vicarious liability?

- A) A manufacturer being held liable for a defective product
- B) An employer being held liable for the actions of an employee during work hours
- C) A homeowner being liable for injuries on their property
- D) A driver being liable for running a red light

Correct Answer: B) An employer being held liable for the actions of an employee during work hours

Question 197

What is the purpose of punitive damages?

- A) To compensate for actual losses
- B) To compensate for non-monetary losses
- C) To reimburse specific monetary losses
- D) To punish the wrongdoer and deter future misconduct

Correct Answer: D) To punish the wrongdoer and deter future misconduct

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Question 198

Which of the following is a requirement under the Fair Credit Reporting Act (FCRA)?

- A) Consumers must pay for access to their credit report
- B) Consumer reporting agencies must ensure the accuracy and fairness of information
- C) Information can be used for any purpose without restriction
- D) Consumers cannot dispute inaccurate information

Correct Answer: B) Consumer reporting agencies must ensure the accuracy and fairness of information

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Question 199

What is the difference between blanket insurance and specific insurance?

- A) Blanket insurance covers a single item, while specific insurance covers multiple items
- B) Blanket insurance covers multiple items or locations under a single policy, while specific insurance covers a particular item or location
- C) Blanket insurance is temporary, while specific insurance is permanent
- D) Blanket insurance is more expensive than specific insurance

Correct Answer: B) Blanket insurance covers multiple items or locations under a single policy, while specific insurance covers a particular item or location

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Question 200

What is the role of a certificate of insurance?

- A) To provide temporary coverage until a permanent policy is issued
- B) To serve as a promise that certain conditions will be met
- C) To provide evidence of insurance coverage
- D) To adjust the premium based on actual records

Correct Answer: C) To provide evidence of insurance coverage

Question 201

What is the primary purpose of the declarations page in an insurance policy?

- A) To provide detailed legal definitions of terms used in the policy
- B) To summarize the key details of the policy, including coverage limits and premium amount
- C) To list all possible exclusions in the policy
- D) To outline the duties and responsibilities of the insured

Correct Answer: B) To summarize the key details of the policy, including coverage limits and premium amount

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Question 202

Which of the following is NOT typically included on an auto insurance declarations page?

- A) Coverage limits
- B) Deductibles
- C) Detailed policy exclusions
- D) Premium amount

Correct Answer: C) Detailed policy exclusions

Question 203

In an insurance policy, what is the insuring agreement?

- A) A summary of the policy's key details
- B) The section that outlines the insurer’s promise to pay for covered losses
- C) A list of specific situations not covered by the policy
- D) The responsibilities of the insured after a loss

Correct Answer: B) The section that outlines the insurer’s promise to pay for covered losses

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Question 204

What are exclusions in an insurance policy?

- A) Situations or perils that are not covered by the policy
- B) The duties and responsibilities of the insured
- C) The insurer’s promise to pay for covered losses
- D) The summary of the policy's key details

Correct Answer: A) Situations or perils that are not covered by the policy

Question 205

Who is considered the insured in an insurance policy?

- A) Only the person whose name is on the policy
- B) The person or entity covered by the policy, including unnamed family members
- C) The insurance company providing the coverage
- D) The broker who sold the policy

Correct Answer: B) The person or entity covered by the policy, including unnamed family members

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Question 206

What is the role of the insurer in an insurance policy?

- A) To sell the policy to the insured
- B) To underwrite the policy and pay claims
- C) To provide legal advice to the insured
- D) To manage the insured's financial investments

Correct Answer: B) To underwrite the policy and pay claims

Question 207

Which of the following is a duty of the insured after experiencing a loss?

- A) Conceal material information from the insurer
- B) Promptly notify the insurer and protect the property from further damage
- C) Delay reporting the loss to the authorities
- D) Ignore the insurer's requests for documentation

Correct Answer: B) Promptly notify the insurer and protect the property from further damage

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Question 208

What is the main difference between renters' insurance and homeowner's' insurance declarations pages?

- A) Renters' insurance includes mortgage details
- B) Homeowner's' insurance covers personal property limits
- C) Renters' insurance lacks mortgage details and covers personal property
- D) Homeowner's' insurance does not include any discounts

Correct Answer: C) Renters' insurance lacks mortgage details and covers personal property

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Question 209

Which of the following is NOT a typical duty of the insured?

- A) Disclose material information
- B) Provide proof of loss to the insurer
- C) Conceal information from the insurer
- D) Report loss or damage to the authorities

Correct Answer: C) Conceal information from the insurer

Question 210

What information is typically found on a homeowner's insurance declarations page?

- A) The insurer's detailed financial statements
- B) The insured's name, property address, coverage limits, and premium
- C) A list of all possible natural disasters
- D) The insured's credit score

Correct Answer: B) The insured's name, property address, coverage limits, and premium

Question 211

What is the primary obligation of an insurance company under an insurance contract?

- A) To maximize profits
- B) To investigate claims and pay covered losses
- C) To provide loans to policyholders
- D) To offer discounts on premiums

Correct Answer: B) To investigate claims and pay covered losses

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Question 212

What does the duty of good faith and fair dealing require from an insurance company?

- A) To act in the client's best interest
- B) To prioritize the company's financial interests
- C) To delay claim processing
- D) To increase premiums annually

Correct Answer: A) To act in the client's best interest

Question 213

What is a mortgagee clause in a property insurance policy?

- A) A clause that reduces the premium for the homeowner
- B) A clause that protects the mortgage lender from losses due to property damage
- C) A clause that allows the homeowner to cancel the policy at any time
- D) A clause that increases the coverage limit for the homeowner

Correct Answer: B) A clause that protects the mortgage lender from losses due to property damage

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Question 214

Who is the mortgagee in a mortgage transaction?

- A) The borrower
- B) The lender
- C) The insurance company
- D) The real estate agent

Correct Answer: B) The lender

Question 215

What is a proof of loss in the context of insurance claims?

- A) A document that provides evidence of insurance coverage
- B) A formal statement made by the insured detailing the extent of the loss and the amount being claimed
- C) A receipt for premium payment
- D) A certificate of policy renewal

Correct Answer: B) A formal statement made by the insured detailing the extent of the loss and the amount being claimed

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Question 216

Which of the following is NOT typically required to file a proof of loss?

- A) General liability insurance
- B) Business owner's policy
- C) Workers' compensation insurance
- D) Personal savings account

Correct Answer: D) Personal savings account

Question 217

What happens if an insurance company breaches its duty of good faith and fair dealing?

- A) The policyholder can sue for damages
- B) The policyholder must pay a penalty
- C) The insurance company receives a bonus
- D) The policyholder's coverage is automatically doubled

Correct Answer: A) The policyholder can sue for damages

Question 218

What is the purpose of a mortgagee clause in a homeowner’s insurance policy?

- A) To ensure the homeowner receives a payout before the lender
- B) To protect the lender's financial interest in the property
- C) To allow the homeowner to refinance the mortgage
- D) To provide additional coverage for natural disasters

Correct Answer: B) To protect the lender's financial interest in the property

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Question 219

In the event of a property damage claim, who is typically paid first under a mortgagee clause?

- A) The homeowner
- B) The insurance agent
- C) The mortgage lender
- D) The local government

Correct Answer: C) The mortgage lender

Question 220

What is the role of an insurance company in defending a policyholder under certain circumstances?

- A) To provide legal representation if the policyholder is sued
- B) To increase the policyholder's premium
- C) To sell the policyholder's assets
- D) To cancel the policyholder's coverage

Correct Answer: A) To provide legal representation if the policyholder is sued

Question 221

What is a key element that must be included in a proof of loss form?

- A) The name of the insurance agent
- B) A complete description of the loss
- C) The weather forecast on the date of the incident
- D) The insured's favorite color

Correct Answer: B) A complete description of the loss

Question 222

When should you file your proof of loss with your insurer?

- A) Within 30 days of the incident
- B) As soon as possible, but no later than the date specified in your policy
- C) Only after receiving a police report
- D) After consulting with a lawyer

Correct Answer: B) As soon as possible, but no later than the date specified in your policy

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Question 223

Which of the following is NOT a reason an insurer might refuse to accept your proof of loss form?

- A) You didn’t answer all the questions
- B) You failed to include supporting documentation
- C) You requested a higher amount of benefits than expected
- D) You didn’t have your signature notarized

Correct Answer: C) You requested a higher amount of benefits than expected

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Question 224

What is the purpose of a Notice of Insurance Claim?

- A) To inform the insurer about your intention to file an insurance claim
- B) To request a loan from the insurance company
- C) To cancel your insurance policy
- D) To change the beneficiary of your policy

Correct Answer: A) To inform the insurer about your intention to file an insurance claim

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Question 225

Which of the following is a key element of a Notice of Insurance Claim?

- A) The claimant's favorite hobby
- B) A brief description of the accident
- C) The weather conditions on the day of the accident
- D) The claimant's social security number

Correct Answer: B) A brief description of the accident

Question 226

What is an appraisal?

- A) A legal document transferring property ownership
- B) A professional assessment of the value of property
- C) A type of insurance policy
- D) A method of calculating insurance premiums

Correct Answer: B) A professional assessment of the value of property

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Question 227

Why are appraisals important in real estate transactions?

- A) They determine the color of the house
- B) They help banks avoid losses on a loan
- C) They set the interest rate for a mortgage
- D) They determine the number of bedrooms in a house

Correct Answer: B) They help banks avoid losses on a loan

Question 228

What is the difference between a home appraisal and a home inspection?

- A) An appraisal assesses the home's value, while an inspection checks the home's condition
- B) An appraisal is done by the homeowner, while an inspection is done by the buyer
- C) An appraisal is optional, while an inspection is mandatory
- D) An appraisal is cheaper than an inspection

Correct Answer: A) An appraisal assesses the home's value, while an inspection checks the home's condition

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Question 229

What happens after you file your proof of loss?

- A) The insurer immediately pays the claim
- B) The insurer reviews the proof of loss and determines coverage
- C) The insurer cancels your policy
- D) The insurer increases your premium

Correct Answer: B) The insurer reviews the proof of loss and determines coverage

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Question 230

What should you do if you don't accept your insurer's settlement offer?

- A) Cancel your insurance policy
- B) Negotiate with the insurer for a larger settlement
- C) File a lawsuit immediately
- D) Accept the offer without question

Correct Answer: B) Negotiate with the insurer for a larger settlement

Question 231

What is the primary purpose of obtaining a professional appraisal for collectibles or antiques?

- A) To ensure the item is sold quickly
- B) To get a fair and unbiased valuation
- C) To increase the item's market value
- D) To avoid paying taxes

Correct Answer: B) To get a fair and unbiased valuation

Question 232

Which organization is recommended for finding an accredited professional appraiser?

- A) National Appraisers Association
- B) American Society of Appraisers
- C) International Valuation Group
- D) Global Appraisal Network

Correct Answer: B) American Society of Appraisers

Question 233

Why might a homeowner need an appraisal for insurance purposes?

- A) To reduce insurance premiums
- B) To establish the value of personal property for coverage
- C) To avoid paying insurance altogether
- D) To increase the insurance policy limit automatically

Correct Answer: B) To establish the value of personal property for coverage

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Question 234

What is the typical cost range for a home appraisal for a single-family property?

- A) $100 to $200
- B) $200 to $300
- C) $300 to $450
- D) $450 to $600

Correct Answer: C) $300 to $450

Question 235

What can a buyer do if they disagree with the appraisal report?

- A) Accept the report without question
- B) Request a reconsideration or a second appraisal
- C) Sue the appraiser
- D) Ignore the appraisal and proceed with the purchase

Correct Answer: B) Request a reconsideration or a second appraisal

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Question 236

Which of the following is NOT a recommended way to improve your home's appraisal value?

- A) Clean and declutter rooms
- B) Make minor cosmetic improvements
- C) Point out major improvements to the appraiser
- D) Undertake large, expensive renovations

Correct Answer: D) Undertake large, expensive renovations

Question 237

In what scenario is a home appraisal almost always required?

- A) When purchasing a home with a mortgage
- B) When buying a home with cash
- C) When selling a home without an agent
- D) When renting a property

Correct Answer: A) When purchasing a home with a mortgage

Question 238

What is the role of an appraisal clause in an insurance contract?

- A) To automatically increase the value of insured items
- B) To specify that the owner agrees to obtain an appraisal in case of a dispute
- C) To eliminate the need for appraisals
- D) To reduce the insurance premium

Correct Answer: B) To specify that the owner agrees to obtain an appraisal in case of a dispute

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Question 239

What is the main reason appraisers look at comparable homes in the area during a home appraisal?

- A) To determine the neighborhood's popularity
- B) To estimate the home's value based on similar properties
- C) To find potential buyers for the home
- D) To assess the local crime rate

Correct Answer: B) To estimate the home's value based on similar properties

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Question 240

What is a potential consequence if a home appraisal comes in too low compared to the agreed purchase price?

- A) The buyer must cancel the purchase
- B) The seller is required to lower the price
- C) The buyer may need to pay the difference out of pocket
- D) The appraisal is automatically adjusted to match the purchase price

Correct Answer: C) The buyer may need to pay the difference out of pocket

Question 241

What is the primary purpose of an other insurance provision in an insurance policy?

- A) To increase the total coverage amount
- B) To specify how coverage will be apportioned if multiple policies cover the same risk
- C) To reduce the premium cost
- D) To eliminate the need for a deductible

Correct Answer: B) To specify how coverage will be apportioned if multiple policies cover the same risk

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Question 242

Which of the following best describes subrogation in the context of insurance?

- A) The process of an insurer paying a claim and then seeking reimbursement from the insured
- B) The legal right of insurers to pursue a third party that caused an insurance loss to the insured
- C) The act of an insured party waiving their right to sue a third party
- D) The method by which insurers determine the primary policy in a claim

Correct Answer: B) The legal right of insurers to pursue a third party that caused an insurance loss to the insured

Question 243

What is the role of primary insurance in the context of an other insurance clause?

- A) It is the last coverage to come into effect
- B) It is the first coverage that will come into effect when the policyholder suffers an insured loss
- C) It is the coverage that only applies if other policies are exhausted
- D) It is the coverage that applies only to minor claims

Correct Answer: B) It is the first coverage that will come into effect when the policyholder suffers an insured loss

Question 244

How does subrogation benefit the insured party?

- A) It allows the insured to receive payments more quickly
- B) It increases the insured's premium rates
- C) It requires the insured to participate actively in legal proceedings
- D) It limits the insured's coverage options

Correct Answer: A) It allows the insured to receive payments more quickly

Question 245

What is a waiver of subrogation?

- A) A clause that allows insurers to pursue any party for reimbursement
- B) A contractual provision where an insured waives the right of their insurance carrier to seek compensation from a negligent third party
- C) A policy that increases the insured's deductible
- D) A clause that mandates the insured to pursue legal action against a third party

Correct Answer: B) A contractual provision where an insured waives the right of their insurance carrier to seek compensation from a negligent third party

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Question 246

In which type of insurance policy is subrogation most commonly found?

- A) Life insurance
- B) Auto insurance
- C) Travel insurance
- D) Pet insurance

Correct Answer: B) Auto insurance

Question 247

What happens if a settlement occurs outside of the normal subrogation process?

- A) The insurer can still pursue subrogation against the at-fault party
- B) It is often legally impossible for the insurer to pursue subrogation against the at-fault party
- C) The insured must pay back the settlement amount to the insurer
- D) The insurer automatically increases the insured's premium

Correct Answer: B) It is often legally impossible for the insurer to pursue subrogation against the at-fault party

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Question 248

What is the main risk associated with overinsurance?

- A) The insured may have to pay higher premiums
- B) The insured could earn a profit from their insurance policies
- C) The insured might not receive any coverage
- D) The insured will have to deal with multiple insurers

Correct Answer: B) The insured could earn a profit from their insurance policies

Question 249

Which of the following is a benefit of subrogation for insurance companies?

- A) It allows them to increase the insured's deductible
- B) It improves loss ratios, profits, and underwriting revenue
- C) It reduces the need for legal proceedings
- D) It eliminates the need for other insurance provisions

Correct Answer: B) It improves loss ratios, profits, and underwriting revenue

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Question 250

What does the subrogation process allow the insurer to do after paying a claim?

- A) Increase the insured's premium rates
- B) Recover the claim amount from the parties who are at fault for the loss
- C) Cancel the insured's policy
- D) Reduce the coverage amount for future claims

Correct Answer: B) Recover the claim amount from the parties who are at fault for the loss

Question 251

What is the first essential element of a contract?

- A) Acceptance
- B) Offer
- C) Consideration
- D) Legality

Correct Answer: B) Offer

Question 252

Which of the following statements is true regarding an "invitation to treat"?

- A) It is a firm offer that must be accepted.
- B) It is an invitation for others to make offers.
- C) It is a legally binding contract.
- D) It is a counter-offer.

Correct Answer: B) It is an invitation for others to make offers.

Question 253

In the context of contracts, what does "puffery" refer to?

- A) A legally binding promise.
- B) A false statement intended to deceive.
- C) An exaggerated statement not meant to be taken literally.
- D) A counter-offer.

Correct Answer: C) An exaggerated statement not meant to be taken literally.

Question 254

What happens when a counter-offer is made?

- A) The original offer is accepted.
- B) The original offer is rejected and replaced with a new offer.
- C) The original offer becomes legally binding.
- D) The original offer is ignored.

Correct Answer: B) The original offer is rejected and replaced with a new offer.

Question 255

Which of the following is NOT considered valid consideration in a contract?

- A) A promise to perform a service.
- B) A gift given voluntarily without any request.
- C) Payment of money.
- D) Exchange of goods.

Correct Answer: B) A gift given voluntarily without any request.

Question 256

What is the legal principle that allows a promise to be enforced even without consideration, if a party relied on it to their detriment?

- A) Statute of Frauds
- B) Promissory Estoppel
- C) Invitation to Treat
- D) Mirror Image Rule

Correct Answer: B) Promissory Estoppel

Question 257

Which of the following contracts must be in writing to be enforceable under the Statute of Frauds?

- A) A contract for the sale of a car.
- B) A contract for the sale of real property.
- C) A contract for a service to be completed in one month.
- D) A contract for a gift.

Correct Answer: B) A contract for the sale of real property.

Question 258

What is the difference between a bilateral and a unilateral contract?

- A) A bilateral contract involves one party, while a unilateral contract involves two parties.
- B) A bilateral contract requires acceptance, while a unilateral contract does not.
- C) A bilateral contract involves mutual promises, while a unilateral contract involves a promise in exchange for performance.
- D) A bilateral contract is always written, while a unilateral contract is always oral.

Correct Answer: C) A bilateral contract involves mutual promises, while a unilateral contract involves a promise in exchange for performance.

Question 259

Which of the following is true about a minor's capacity to enter into a contract?

- A) Minors cannot enter into any contracts.
- B) Contracts with minors are always enforceable.
- C) Contracts with minors are voidable at the minor's discretion.
- D) Minors can only enter into contracts for luxury items.

Correct Answer: C) Contracts with minors are voidable at the minor's discretion.

Question 260

What is required for acceptance in a contract to be valid?

- A) Acceptance must be communicated and be a mirror image of the offer.
- B) Acceptance can be implied through silence.
- C) Acceptance must include a counter-offer.
- D) Acceptance can be vague and ambiguous.

Correct Answer: A) Acceptance must be communicated and be a mirror image of the offer.

Question 261

What is a warranty in the context of insurance?

- A) A promise made by the insurer to pay claims promptly.
- B) A promise made by the insured that certain conditions will be met.
- C) A statement made by the insured that is believed to be true.
- D) The intentional withholding of information by the insured.

Correct Answer: B) A promise made by the insured that certain conditions will be met.

Question 262

Which of the following best describes concealment in insurance terms?

- A) Providing false information on an insurance application.
- B) Intentionally withholding material information by the insured.
- C) Making a promise to maintain certain conditions.
- D) A statement believed to be true by the insured.

Correct Answer: B) Intentionally withholding material information by the insured.

Question 263

What is the primary purpose of the Fair Credit Reporting Act (FCRA)?

- A) To regulate the insurance industry.
- B) To promote the accuracy, fairness, and privacy of consumer credit reports.
- C) To provide a government backstop for terrorism-related insurance claims.
- D) To define the geographic area where insurance coverage applies.

Correct Answer: B) To promote the accuracy, fairness, and privacy of consumer credit reports.

Question 264

What does the Gramm-Leach-Bliley Act require financial institutions to do?

- A) Provide a government backstop for terrorism-related insurance claims.
- B) Explain their information-sharing practices and protect consumers' private information.
- C) Promote the accuracy of consumer credit reports.
- D) Define the geographic area where insurance coverage applies.

Correct Answer: B) Explain their information-sharing practices and protect consumers' private information.

Question 265

What is the main function of underwriting in the insurance industry?

- A) To provide legal advice to policyholders.
- B) To assess and price the risk of insuring a person or entity.
- C) To investigate fraudulent claims.
- D) To promote consumer rights in credit reporting.

Correct Answer: B) To assess and price the risk of insuring a person or entity.

Question 266

Which of the following is an example of a source of underwriting information?

- A) A warranty in an insurance policy.
- B) A consumer's credit report.
- C) A policy application form.
- D) A privacy notice from a bank.

Correct Answer: B) A consumer's credit report.

Question 267

What does the Terrorism Risk Insurance Act (TRIA) provide?

- A) A system for promoting the accuracy of credit reports.
- B) A government backstop for insurance claims related to acts of terrorism.
- C) A requirement for financial institutions to protect consumer information.
- D) A definition of the geographic area where insurance coverage applies.

Correct Answer: B) A government backstop for insurance claims related to acts of terrorism.

Question 268

What is the purpose of a policy application in insurance?

- A) To request insurance coverage.
- B) To provide a privacy notice to consumers.
- C) To assess the risk of insuring a person or entity.
- D) To define the geographic area where coverage applies.

Correct Answer: A) To request insurance coverage.

Question 269

Which type of liability is covered under Commercial General Liability (CGL) insurance for bodily injury or property damage occurring on the insured's premises?

- A) Products and Completed Operations Liability
- B) Premises and Operations Liability
- C) Contractual Liability
- D) Personal and Advertising Liability

Correct Answer: B) Premises and Operations Liability

Question 270

What does the territory provision in an insurance policy define?

- A) The types of risks covered by the policy.
- B) The geographic area where coverage applies.
- C) The conditions under which a claim can be made.
- D) The privacy practices of the insurer.

Correct Answer: B) The geographic area where coverage applies.

Question 271

What does Commercial General Liability (CGL) insurance primarily cover?

- A) Claims for which businesses may become legally liable
- B) Damage to the insured's own property
- C) Employee health benefits
- D) Losses due to market fluctuations

Correct Answer: A) Claims for which businesses may become legally liable

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Question 272

Which of the following is NOT a basic hazard covered by CGL insurance?

- A) Premises and Operations liability
- B) Products and Completed Operations liability
- C) Cybersecurity liability
- D) Independent Contractors liability

Correct Answer: C) Cybersecurity liability

Question 273

What is the basis for calculating the premium for Premises liability under CGL insurance?

- A) Gross annual sales
- B) Size of the premises and public accessibility
- C) Number of employees
- D) Type of products sold

Correct Answer: B) Size of the premises and public accessibility

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Question 274

Which coverage form under CGL insurance provides protection against personal injury and advertising injury liability?

- A) Coverage A
- B) Coverage B
- C) Coverage C
- D) Coverage D

Correct Answer: B) Coverage B

Question 275

What type of liability is covered under the "Insured Contracts" provision of CGL insurance?

- A) Liability for pollution cleanup
- B) Liability assumed under specific contracts
- C) Liability for product recalls
- D) Liability for intentional injuries

Correct Answer: B) Liability assumed under specific contracts

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Question 276

Which of the following is an exclusion under Coverage A of CGL insurance?

- A) Bodily injury due to negligence
- B) Liability arising out of expected or intentional injury
- C) Property damage on the insured's premises
- D) Medical payments to others

Correct Answer: B) Liability arising out of expected or intentional injury

Question 277

What is the primary factor for determining the premium for Products liability under CGL insurance?

- A) Number of employees
- B) Gross annual sales
- C) Size of the premises
- D) Type of operations conducted

Correct Answer: B) Gross annual sales

Question 278

Which of the following is covered under Completed Operations liability?

- A) Damage to the insured's own product
- B) Bodily injury due to faulty construction after work completion
- C) Pollution cleanup costs
- D) Employee injuries covered by workers' compensation

Correct Answer: B) Bodily injury due to faulty construction after work completion

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Question 279

What type of liability is provided by Owners and Contractors Protective insurance under CGL?

- A) Direct liability
- B) Contingent liability
- C) Cyber liability
- D) Environmental liability

Correct Answer: B) Contingent liability

Question 280

Which of the following is NOT covered by CGL insurance under the Products liability?

- A) Bodily injury caused by a faulty product
- B) Property damage caused by a faulty product
- C) Cost of a product recall
- D) Liability after the product has left the premises

Correct Answer: C) Cost of a product recall

Question 281

What is the primary purpose of Fire Legal Liability in a commercial lease agreement?

- A) To cover all types of property damage
- B) To cover property damage caused by fire due to the tenant's negligence
- C) To cover pollution-related damages
- D) To cover personal injury claims

Correct Answer: B) To cover property damage caused by fire due to the tenant's negligence

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Question 282

Which of the following is NOT covered under the Pollution Liability Coverage Extension Endorsement?

- A) Bodily injury due to pollution
- B) Property damage due to pollution
- C) Cost of pollutant clean-up
- D) Emissions of pollutants into the atmosphere

Correct Answer: C) Cost of pollutant clean-up

Question 283

What type of coverage is provided by Coverage B in a Commercial General Liability policy?

- A) Fire damage liability
- B) Personal Injury and Advertising Injury
- C) Pollution liability
- D) Medical payments

Correct Answer: B) Personal Injury and Advertising Injury

Question 284

Which of the following is an exclusion under Coverage B for Personal Injury and Advertising Injury?

- A) Invasion of privacy
- B) Libel
- C) Knowingly violating another’s rights
- D) Malicious prosecution

Correct Answer: C) Knowingly violating another’s rights

Question 285

What is the main purpose of Coverage C: Medical Payments in a Commercial General Liability policy?

- A) To cover legal liability due to negligence
- B) To cover necessary medical expenses regardless of fault
- C) To cover property damage
- D) To cover pollution-related incidents

Correct Answer: B) To cover necessary medical expenses regardless of fault

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Question 286

Which of the following is NOT a supplementary payment covered under a Commercial General Liability policy?

- A) Expenses the insurance company incurs
- B) Cost of bonds to release attachments
- C) Medical expenses for the insured
- D) Prejudgment interest

Correct Answer: C) Medical expenses for the insured

Question 287

In an Occurrence Form policy, when is coverage triggered?

- A) When a claim is filed during the policy period
- B) When an occurrence takes place during the policy period
- C) When the policy is renewed
- D) When the policy is canceled

Correct Answer: B) When an occurrence takes place during the policy period

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Question 288

What is the purpose of a Retroactive Date in a Claims-Made Form policy?

- A) To extend the policy period indefinitely
- B) To specify a date before which losses are not covered
- C) To provide coverage for future claims
- D) To determine the premium amount

Correct Answer: B) To specify a date before which losses are not covered

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Question 289

Which of the following is NOT a condition for Medical Payments coverage under Coverage C?

- A) The accident must occur in the coverage territory
- B) Medical expenses must be reported within one year
- C) The insured must be found legally liable
- D) Coverage is on a per person basis

Correct Answer: C) The insured must be found legally liable

Question 290

Which of the following is an example of an Advertising Injury under Coverage B?

- A) False arrest
- B) Copyright infringement
- C) Malicious prosecution
- D) Invasion of privacy

Correct Answer: B) Copyright infringement

Question 291

What is the purpose of the Extended Reporting Period (ERP) in an insurance policy?

- A) To extend the policy period itself
- B) To extend the time in which a claim can be reported to the insurer
- C) To increase the coverage limits
- D) To reduce the premium costs

Correct Answer: B) To extend the time in which a claim can be reported to the insurer

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Question 292

Which of the following is true about the Basic Extended Reporting Period?

- A) It requires an additional premium
- B) It provides an indefinite extension for reporting claims
- C) It starts at the end of the policy period and provides an additional 60 days for reporting claims
- D) It can be cancelled at any time

Correct Answer: C) It starts at the end of the policy period and provides an additional 60 days for reporting claims

Question 293

What is the maximum additional premium that may be charged for a Supplemental Extended Reporting Period?

- A) 100% of the annual Commercial General Liability policy premium
- B) 150% of the annual Commercial General Liability policy premium
- C) 200% of the annual Commercial General Liability policy premium
- D) 250% of the annual Commercial General Liability policy premium

Correct Answer: C) 200% of the annual Commercial General Liability policy premium

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Question 294

Who is considered an insured under a Commercial General Liability policy for a limited liability company?

- A) Only the named insured
- B) Members and managers, but only in connection with their duties
- C) Only the executive officers
- D) Only the stockholders

Correct Answer: B) Members and managers, but only in connection with their duties

Question 295

What happens if a claims-made policy is replaced with an occurrence form policy?

- A) There is no change in coverage
- B) There may be a gap in coverage for incidents not reported within the policy period of the claims-made form
- C) The retroactive date is automatically advanced
- D) The policy limits are doubled

Correct Answer: B) There may be a gap in coverage for incidents not reported within the policy period of the claims-made form

Question 296

What is the role of the first named insured in an insurance policy?

- A) To pay the premiums only
- B) To have the authority to make changes, file claims, and receive communications from the insurer
- C) To act as a legal representative of the insurer
- D) To manage the insurer's investments

Correct Answer: B) To have the authority to make changes, file claims, and receive communications from the insurer

Question 297

Which limit is reset at the start of a new policy period in a Commercial General Liability policy?

- A) Per Occurrence limit
- B) Medical Expense limit
- C) General Aggregate limit
- D) Personal and Advertising Injury limit

Correct Answer: C) General Aggregate limit

Question 298

What is the Personal and Advertising Injury limit subject to?

- A) The Products and Completed Operations Aggregate limit
- B) The General Aggregate limit
- C) The Per Occurrence limit
- D) The Medical Expense limit

Correct Answer: B) The General Aggregate limit

Question 299

Under what condition is automatic coverage provided for newly acquired or formed organizations?

- A) The organization must be a partnership
- B) The named insured must maintain ownership or a majority interest in the new organization
- C) The organization must have similar insurance available
- D) The organization must be a joint venture

Correct Answer: B) The named insured must maintain ownership or a majority interest in the new organization

Question 300

What is the maximum amount the insurer will pay for fire damage to premises rented to the insured?

- A) The General Aggregate limit
- B) The Products and Completed Operations Aggregate limit
- C) The Damage to Premises Rented to the Insured limit
- D) The Medical Expense limit

Correct Answer: C) The Damage to Premises Rented to the Insured limit

Question 301

What is the primary purpose of the "Damage to Property of Others Conditions" in an insurance policy?

- A) To outline the insurer's responsibilities and the insured's obligations when damage occurs to property owned by others.
- B) To provide a list of all possible damages that can occur to the insured's property.
- C) To determine the value of the insured's property.
- D) To specify the premium amount for the insurance policy.

Correct Answer: A) To outline the insurer's responsibilities and the insured's obligations when damage occurs to property owned by others.

Question 302

Which of the following is NOT included in the definition of "Mobile Equipment"?

- A) Bulldozers and farm machinery
- B) Vehicles designed for travel on public roads
- C) Vehicles that travel on crawler treads
- D) Vehicles providing mobility to permanently mounted power cranes

Correct Answer: B) Vehicles designed for travel on public roads

Question 303

What does "Split Limits" in automotive insurance refer to?

- A) A single limit that covers both bodily injury and property damage.
- B) Separate coverage limits for bodily injury per person, per accident, and property damage per accident.
- C) Coverage for damages if you're hit by a driver without insurance.
- D) Coverage for medical expenses for you and your passengers, regardless of fault.

Correct Answer: B) Separate coverage limits for bodily injury per person, per accident, and property damage per accident.

Question 304

In the context of insurance, what is "Subrogation"?

- A) The insurer's right to audit the insured’s books and records.
- B) The insured's agreement to transfer any rights to recover payments made by the insurer.
- C) The process of renewing an insurance policy.
- D) The method of calculating insurance premiums.

Correct Answer: B) The insured's agreement to transfer any rights to recover payments made by the insurer.

Question 305

Which of the following is considered "Impaired Property"?

- A) Tangible property that is less useful because it incorporates the insured's defective product.
- B) Any property owned by the insured.
- C) Property that is permanently damaged and cannot be restored.
- D) Property that is not covered by any insurance policy.

Correct Answer: A) Tangible property that is less useful because it incorporates the insured's defective product.

Question 306

What is covered under "Uninsured Motorists" coverage?

- A) Damages if you're hit by a driver with insufficient insurance.
- B) Damages if you're hit by a driver without insurance.
- C) Medical expenses for you and your passengers, regardless of fault.
- D) Damage to your vehicle from a collision, regardless of fault.

Correct Answer: B) Damages if you're hit by a driver without insurance.

Question 307

Which of the following is NOT considered "Mobile Equipment"?

- A) Forklifts
- B) Vehicles maintained for use solely on or next to premises the insured owns or rents
- C) Personal cars used for daily commuting
- D) Vehicles that provide mobility to permanently mounted power cranes

Correct Answer: C) Personal cars used for daily commuting

Question 308

What does "Combined Single Limit" mean in automotive insurance?

- A) A limit that covers only bodily injury.
- B) A limit that covers only property damage.
- C) A single limit that covers both bodily injury and property damage.
- D) A limit that covers medical expenses for you and your passengers.

Correct Answer: C) A single limit that covers both bodily injury and property damage.

Question 309

What is the definition of "Pollutants" in the context of insurance?

- A) Any solid, liquid, gaseous, or thermal irritant or contaminant.
- B) Only liquid contaminants.
- C) Only gaseous irritants.
- D) Only thermal irritants.

Correct Answer: A) Any solid, liquid, gaseous, or thermal irritant or contaminant.

Question 310

What is the coverage territory usually defined as in a Commercial General Liability policy?

- A) Only the United States of America.
- B) The United States of America, including its territories or possessions, Puerto Rico, and Canada.
- C) Only international waters.
- D) Only the state where the insured resides.

Correct Answer: B) The United States of America, including its territories or possessions, Puerto Rico, and Canada.

Question 311

What type of coverage does the Auto Dealers Coverage Form provide for auto dealerships?

- A) Liability and physical damage
- B) Medical payments
- C) Uninsured motorists
- D) Mobile equipment

Correct Answer: A) Liability and physical damage

Question 312

Which of the following is an example of a situation covered by Garagekeepers Insurance?

- A) A dealership is sued for selling a defective car.
- B) A customer's car is damaged while being serviced at the dealership.
- C) Damage from normal wear and tear.
- D) A forklift in a warehouse is damaged.

Correct Answer: B) A customer's car is damaged while being serviced at the dealership.

Question 313

What does the Drive Other Car (DOC) coverage extend to the named insured?

- A) Coverage for vehicles primarily used on public roads
- B) Liability coverage when driving a vehicle not owned or listed on their policy
- C) Coverage for damage to the insured's own vehicle
- D) Coverage for uninsured motorists

Correct Answer: B) Liability coverage when driving a vehicle not owned or listed on their policy

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Question 314

Which of the following is typically excluded from coverage under the Auto Dealers Coverage Form?

- A) Damage from a collision
- B) Damage from normal wear and tear
- C) Damage to a customer's vehicle while in the dealership's care
- D) Damage from theft

Correct Answer: B) Damage from normal wear and tear

Question 315

What is the purpose of the Lease Gap coverage?

- A) To cover the difference between the actual cash value of a leased vehicle and the remaining balance on the lease in the event of a total loss
- B) To provide coverage for vehicles not owned by the insured but used for business purposes
- C) To cover medical payments for injuries sustained in an auto accident
- D) To provide liability coverage for vehicles used for delivery

Correct Answer: A) To cover the difference between the actual cash value of a leased vehicle and the remaining balance on the lease in the event of a total loss

Question 316

Which part of the Personal Auto Policy provides coverage for damage to the insured's own automobile?

- A) Part A – Liability coverage
- B) Part B – Medical payments coverage
- C) Part C – Uninsured motorists coverage
- D) Part D – Coverage for damage to your auto

Correct Answer: D) Part D – Coverage for damage to your auto

Question 317

What is the purpose of the Named Non-Owner Coverage endorsement?

- A) To provide coverage for individuals who own a car
- B) To provide coverage for individuals who do not own a car but drive borrowed or rented cars
- C) To provide coverage for snowmobiles
- D) To provide coverage for vehicles used for commercial purposes

Correct Answer: B) To provide coverage for individuals who do not own a car but drive borrowed or rented cars

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Question 318

Which of the following is NOT considered a covered auto under the Personal Auto Policy?

- A) A vehicle listed in the Declarations page
- B) A trailer owned by the named insured
- C) A vehicle used for delivery or commercial purposes
- D) A private passenger vehicle acquired during the policy period

Correct Answer: C) A vehicle used for delivery or commercial purposes

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Question 319

What does the Extended Non-Owned Coverage endorsement provide?

- A) Coverage for owned vehicles only
- B) Coverage for non-owned autos furnished for the insured’s regular use
- C) Coverage for snowmobiles
- D) Coverage for temporary substitute vehicles

Correct Answer: B) Coverage for non-owned autos furnished for the insured’s regular use

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Question 320

Under the Part A – Liability Insuring Agreement, what is the insurer's duty regarding defense costs?

- A) The insurer will pay defense costs only up to the limits of liability.
- B) The insurer will pay defense costs in addition to the limits of liability.
- C) The insurer will not pay any defense costs.
- D) The insurer will pay defense costs only if the insured is found liable.

Correct Answer: B) The insurer will pay defense costs in addition to the limits of liability.

Question 321

Who is included in the definition of the "Insured" under the policy?

- A) Only the named insured
- B) The named insured and family members using any auto
- C) Only the named insured and their spouse
- D) Only the named insured and their children

Correct Answer: B) The named insured and family members using any auto

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Question 322

Which of the following is covered under Part A – Liability's Supplementary Payments?

- A) Up to $500 for bail bonds
- B) Up to $250 for bail bonds
- C) Up to $100 for bail bonds
- D) Up to $300 for bail bonds

Correct Answer: B) Up to $250 for bail bonds

Question 323

Which of the following is an exclusion under Part A – Liability coverage?

- A) Damage to a neighbor's property
- B) Intentional bodily injury by the insured
- C) Bodily injury to a pedestrian
- D) Damage to a rental car

Correct Answer: B) Intentional bodily injury by the insured

Question 324

What is the per person limit for bodily injury if the limits of liability are 25/50/25?

- A) $50,000
- B) $25,000
- C) $75,000
- D) $100,000

Correct Answer: B) $25,000

Question 325

Under Part B – Medical Payments, who is covered for injuries received in an accident?

- A) Only the named insured
- B) The named insured, family members, and passengers in the named insured's auto
- C) Only passengers in the named insured's auto
- D) Only family members

Correct Answer: B) The named insured, family members, and passengers in the named insured's auto

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Question 326

Which of the following is NOT covered under Part B – Medical Payments?

- A) Injuries sustained while occupying a vehicle used in racing
- B) Injuries sustained while walking
- C) Injuries sustained while cycling
- D) Injuries sustained while occupying a covered auto

Correct Answer: A) Injuries sustained while occupying a vehicle used in racing

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Question 327

What happens if there is more than one auto liability insurance policy in place at the time of a loss?

- A) Each insurer pays the full amount of the loss
- B) Each insurer pays their share of the loss in proportion to their limit of liability
- C) Only the primary insurer pays
- D) The insured pays the loss out of pocket

Correct Answer: B) Each insurer pays their share of the loss in proportion to their limit of liability

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Question 328

Which of the following scenarios would be covered under Part A – Liability?

- A) The insured's car is used as a taxi
- B) The insured's car is used in a share-the-cost car pool
- C) The insured's car is used in a racing contest
- D) The insured's car is used for commercial delivery

Correct Answer: B) The insured's car is used in a share-the-cost car pool

Question 329

What is the role of the Part A Financial Responsibility provision?

- A) To provide coverage for medical expenses
- B) To certify the policy as proof of future financial responsibility
- C) To exclude coverage for intentional damage
- D) To provide coverage for property damage

Correct Answer: B) To certify the policy as proof of future financial responsibility

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Question 330

Which of the following is a specific exclusion under Part B – Medical Payments?

- A) Injuries sustained while occupying a covered auto
- B) Injuries sustained while using a vehicle as a residence
- C) Injuries sustained while walking
- D) Injuries sustained while cycling

Correct Answer: B) Injuries sustained while using a vehicle as a residence

Question 331

What is the primary insurer in the case of a vehicle not owned by the insured?

- A) The driver's policy
- B) The owner's policy
- C) The insured's health plan
- D) The excess insurer

Correct Answer: B) The owner's policy

Question 332

Which of the following is NOT covered under Part D – Physical Damage Insuring Agreement?

- A) Collision
- B) Comprehensive
- C) Personal property in the vehicle
- D) Transportation expenses

Correct Answer: C) Personal property in the vehicle

Question 333

What is the maximum amount Part D will pay for the loss of a nonowned trailer?

- A) $1,000
- B) $1,500
- C) $2,000
- D) $2,500

Correct Answer: B) $1,500

Question 334

Which of the following is considered a collision under Part D coverage?

- A) Hitting a deer
- B) A vehicle hitting a rock in the middle of the road
- C) Theft of the vehicle
- D) Vandalism

Correct Answer: B) A vehicle hitting a rock in the middle of the road

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Question 335

What is the waiting period for transportation expenses coverage for losses arising out of total theft of the auto?

- A) 12 hours
- B) 24 hours
- C) 48 hours
- D) 72 hours

Correct Answer: C) 48 hours

Question 336

Which of the following is NOT considered an uninsured motor vehicle?

- A) A vehicle with no liability coverage at the time of the accident
- B) A vehicle operated by a hit-and-run driver
- C) A vehicle owned by a government unit
- D) A vehicle with insufficient liability coverage to meet state requirements

Correct Answer: C) A vehicle owned by a government unit

Question 337

What is the purpose of medical payments coverage under Part B?

- A) To cover physical damage to the insured's car
- B) To pay for medical expenses for the insured and family members in case of an auto accident
- C) To cover liability for damages to other vehicles
- D) To provide coverage for uninsured motorists

Correct Answer: B) To pay for medical expenses for the insured and family members in case of an auto accident

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Question 338

Which of the following is excluded from Part D coverage?

- A) Collision with another vehicle
- B) Theft of the vehicle
- C) Damage due to wear and tear
- D) Contact with a bird or animal

Correct Answer: C) Damage due to wear and tear

Question 339

What is the maximum daily amount paid for transportation expenses under Part D?

- A) $10
- B) $15
- C) $20
- D) $25

Correct Answer: C) $20

Question 340

Which of the following is NOT a peril covered under comprehensive coverage?

- A) Fire
- B) Earthquake
- C) Collision with another vehicle
- D) Vandalism

Correct Answer: C) Collision with another vehicle

Question 341

What does Symbol 1 cover in the Business Auto Coverage?

- A) Only owned autos
- B) Any auto the insured uses, whether owned or not
- C) Only non-owned autos
- D) Only hired autos

Correct Answer: B) Any auto the insured uses, whether owned or not

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Question 342

Which of the following is NOT covered under the Business Auto Liability coverage?

- A) Temporary substitute vehicles
- B) Trailers with a load capacity of 2,000 pounds or less
- C) Mobile equipment while it is being towed
- D) Sound reproducing equipment

Correct Answer: D) Sound reproducing equipment

Question 343

What is the maximum amount covered for bail bonds under Business Auto supplementary payments?

- A) $500
- B) $1,000
- C) $2,000
- D) $5,000

Correct Answer: C) $2,000

Question 344

Which of the following is considered a "non-owned" auto?

- A) A vehicle owned by the business
- B) A vehicle rented by the insured
- C) An employee's personal vehicle used for business purposes
- D) A vehicle temporarily substituted for a covered auto

Correct Answer: C) An employee's personal vehicle used for business purposes

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Question 345

What is the standard deductible for comprehensive coverage per covered auto per loss?

- A) $250
- B) $500
- C) $750
- D) $1,000

Correct Answer: B) $500

Question 346

Which of the following is NOT a type of physical damage coverage?

- A) Comprehensive
- B) Collision
- C) Liability
- D) Specified causes of loss

Correct Answer: C) Liability

Question 347

What is the maximum coverage for transportation expenses due to theft of a covered vehicle?

- A) $10 per day, $300 total
- B) $15 per day, $450 total
- C) $20 per day, $600 total
- D) $25 per day, $750 total

Correct Answer: C) $20 per day, $600 total

Question 348

Which of the following is specifically excluded from liability coverage?

- A) The named insured
- B) A person working in an auto-related business
- C) Other drivers using a covered vehicle with permission
- D) Those liable for the conduct of an insured

Correct Answer: B) A person working in an auto-related business

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Question 349

What type of coverage does the Garage Coverage form NOT provide?

- A) Liability coverage
- B) Garagekeepers coverage
- C) Physical damage coverage
- D) Health insurance coverage

Correct Answer: D) Health insurance coverage

Question 350

Which of the following is considered "mobile equipment" under the Business Auto Coverage?

- A) Passenger cars
- B) Trucks
- C) Bulldozers
- D) Motorcycles

Correct Answer: C) Bulldozers

Question 351

What is Symbol 30 in the Garage Coverage form used for?

- A) Physical damage coverage for dealer's autos
- B) Customers' autos left with the insured for service, repair, storage, or safekeeping
- C) Liability coverage for garage operations
- D) Trailer interchange coverage

Correct Answer: B) Customers' autos left with the insured for service, repair, storage, or safekeeping

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Question 352

Which of the following is NOT covered under the Garage Coverage form's liability coverage?

- A) An employee taking a customer's car on a test drive
- B) A customer injured on the premises
- C) Damage to the property of others in the insured's care, custody, or control
- D) Product liability related to a bad repair

Correct Answer: C) Damage to the property of others in the insured's care, custody, or control

Question 353

What does the Garagekeepers coverage under the Garage Coverage form include?

- A) Liability for damage to the insured's own vehicles
- B) Liability for damage to the customer’s property in the insured’s care
- C) Coverage for owned private passenger autos
- D) Coverage for product recalls

Correct Answer: B) Liability for damage to the customer’s property in the insured’s care

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Question 354

What is the purpose of the MCS-90 Endorsement?

- A) To provide coverage for mobile equipment
- B) To extend coverage to non-owned autos
- C) To provide public liability coverage for bodily injury, property damage, and environmental restoration
- D) To cover employees using their own vehicles for business use

Correct Answer: C) To provide public liability coverage for bodily injury, property damage, and environmental restoration

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Question 355

Which symbol is used in the Truckers Coverage form for trailers borrowed or leased by the named insured?

- A) Symbol 30
- B) Symbol 31
- C) Symbol 48
- D) Symbol 49

Correct Answer: C) Symbol 48

Question 356

What is the minimum liability limit required by the Motor Carrier Act for vehicles transporting non-hazardous material interstate?

- A) $750,000
- B) $1,000,000
- C) $5,000,000
- D) $10,000,000

Correct Answer: A) $750,000

Question 357

Which endorsement provides personal auto coverage for immediate family members of the named insured?

- A) Drive Other Car Coverage Endorsement
- B) Individual Named Insured
- C) Employees as Additional Insureds
- D) Mobile Equipment Endorsement

Correct Answer: B) Individual Named Insured

Question 358

What type of coverage does the Truckers Coverage form NOT provide?

- A) Liability
- B) Trailer interchange
- C) Physical damage
- D) Owned private passenger autos

Correct Answer: D) Owned private passenger autos

Question 359

Which of the following is a unique feature of the Motor Carrier Coverage form compared to the Truckers Coverage form?

- A) It covers private passenger autos
- B) It includes trailer interchange coverage
- C) It excludes liability coverage
- D) It provides coverage for non-owned autos

Correct Answer: A) It covers private passenger autos

Question 360

What is excluded from the Garagekeepers coverage under the Garage Coverage form?

- A) Collision coverage for customer vehicles
- B) Comprehensive coverage for customer vehicles
- C) Theft of a car by an employee
- D) Direct damage coverage on a primary basis

Correct Answer: C) Theft of a car by an employee

Question 361

What is the primary purpose of workers' compensation insurance?

- A) To provide health insurance for employees
- B) To offer benefits to employees injured or ill due to work-related activities
- C) To cover unemployment benefits
- D) To provide retirement benefits

Correct Answer: B) To offer benefits to employees injured or ill due to work-related activities

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Question 362

Which of the following is NOT considered a work-related injury?

- A) An employee slips and falls at a construction site
- B) An employee injures their ankle while playing soccer on the weekend
- C) An employee develops carpal tunnel syndrome from typing
- D) An employee is injured while lifting heavy boxes at work

Correct Answer: B) An employee injures their ankle while playing soccer on the weekend

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Question 363

What is the "exclusive remedy" principle in workers' compensation?

- A) It allows employees to choose between workers' compensation and suing their employer
- B) It states that workers' compensation is the sole remedy for work-related injuries
- C) It provides additional benefits beyond workers' compensation
- D) It allows employers to deny workers' compensation claims

Correct Answer: B) It states that workers' compensation is the sole remedy for work-related injuries

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Question 364

Which of the following benefits is NOT covered under workers' compensation?

- A) Disability income
- B) Medical expenses
- C) Retirement benefits
- D) Rehabilitation costs

Correct Answer: C) Retirement benefits

Question 365

What is the role of employers liability insurance?

- A) To cover health insurance for employees
- B) To provide coverage for legal fees and settlements when employees sue for damages beyond workers' compensation
- C) To offer unemployment benefits
- D) To provide retirement benefits

Correct Answer: B) To provide coverage for legal fees and settlements when employees sue for damages beyond workers' compensation

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Question 366

Which of the following is a factor in determining workers' compensation insurance premiums?

- A) The employee's age
- B) The type of business and historical claims data
- C) The employee's marital status
- D) The employer's credit score

Correct Answer: B) The type of business and historical claims data

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Question 367

What is the maximum weekly benefit for death/survivor benefits under workers' compensation?

- A) $300.00
- B) $525.00
- C) $750.00
- D) $1,000.00

Correct Answer: B) $525.00

Question 368

Which of the following is NOT a category of disability under workers' compensation?

- A) Permanent total disability
- B) Temporary partial disability
- C) Permanent partial disability
- D) Temporary full disability

Correct Answer: D) Temporary full disability

Question 369

Which federal act allows interstate railroad workers to sue their employers for negligence?

- A) The Longshore and Harbor Workers Compensation Act
- B) The Federal Employers Liability Act (FELA)
- C) The Jones Act
- D) The Social Security Act

Correct Answer: B) The Federal Employers Liability Act (FELA)

Question 370

What is the purpose of the NCCI Experience Modifications in workers' compensation insurance?

- A) To adjust premiums based on a business's claims history and safety record
- B) To provide health insurance for employees
- C) To offer retirement benefits
- D) To determine unemployment benefits

Correct Answer: A) To adjust premiums based on a business's claims history and safety record

Question 371

What type of workers' compensation insurance is available only through the state fund?

- A) Competitive
- B) Monopolistic
- C) Private
- D) Self-insured

Correct Answer: B) Monopolistic

Question 372

In Georgia, how is workers' compensation insurance typically provided?

- A) Through a state fund
- B) By private insurers
- C) By self-insurance only
- D) Through a monopolistic state fund

Correct Answer: B) By private insurers

Question 373

What is the purpose of the Secondary Injury Fund?

- A) To provide insurance for self-insured employers
- B) To encourage employers to hire disabled workers by limiting liability
- C) To cover injuries during lunch breaks
- D) To provide coverage for mysterious disappearances

Correct Answer: B) To encourage employers to hire disabled workers by limiting liability

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Question 374

Which part of the standard workers' compensation policy provides liability insurance for work-related injuries not covered by workers' compensation insurance?

- A) Part One – Workers' Compensation
- B) Part Two – Employers Liability
- C) Part Three – Other States Insurance
- D) Part Four – Your Duties if Injury Occurs

Correct Answer: B) Part Two – Employers Liability

Question 375

What is the minimum policy limit per accident for employers' liability under the standard workers' compensation policy?

- A) $50,000
- B) $75,000
- C) $100,000
- D) $150,000

Correct Answer: C) $100,000

Question 376

Which of the following is NOT covered by workers' compensation insurance?

- A) Injuries sustained while performing assigned duties
- B) Injuries during lunch or break times
- C) Injuries on the employer's premises
- D) Injuries while performing assigned duties off-premises

Correct Answer: B) Injuries during lunch or break times

Question 377

What type of crime coverage protects businesses from financial losses due to fraudulent acts committed by employees?

- A) Theft coverage
- B) Employee dishonesty coverage
- C) Robbery coverage
- D) Burglary coverage

Correct Answer: B) Employee dishonesty coverage

Question 378

Which coverage protects against losses resulting from the use of force or threat of force to steal money or property?

- A) Theft coverage
- B) Burglary coverage
- C) Robbery coverage
- D) Mysterious disappearance coverage

Correct Answer: C) Robbery coverage

Question 379

What is the role of fidelity bonds in crime coverage?

- A) To cover losses from mysterious disappearances
- B) To protect against employee dishonesty, including theft and fraud
- C) To provide coverage for robbery and safe burglary
- D) To insure against natural disasters

Correct Answer: B) To protect against employee dishonesty, including theft and fraud

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Question 380

Which part of the standard workers' compensation policy covers the procedures to be followed in the case of an employee's injury?

- A) Part One – Workers' Compensation
- B) Part Two – Employers Liability
- C) Part Four – Your Duties if Injury Occurs
- D) Part Six – Conditions

Correct Answer: C) Part Four – Your Duties if Injury Occurs

Question 381

What is the primary purpose of commercial crime insurance?

- A) To protect businesses from natural disasters
- B) To protect businesses and government entities from property losses due to crimes such as burglary, robbery, theft, and employee dishonesty
- C) To provide health insurance for employees
- D) To cover legal expenses in all lawsuits

Correct Answer: B) To protect businesses and government entities from property losses due to crimes such as burglary, robbery, theft, and employee dishonesty

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Question 382

Which of the following is NOT covered under the definition of "theft" in crime coverage?

- A) Burglary
- B) Robbery
- C) Extortion
- D) Larceny

Correct Answer: C) Extortion

Question 383

What is the difference between the Loss Sustained Form and the Discovery Form in crime coverage?

- A) The Loss Sustained Form covers losses discovered during the policy period, while the Discovery Form covers losses that occur during the policy period
- B) The Loss Sustained Form covers losses that occur during the policy period, while the Discovery Form covers losses discovered during the policy period
- C) Both forms cover losses discovered and occurring during the policy period
- D) Neither form covers losses discovered or occurring during the policy period

Correct Answer: B) The Loss Sustained Form covers losses that occur during the policy period, while the Discovery Form covers losses discovered during the policy period

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Question 384

Which of the following is defined as the taking of property from inside the premises by a person unlawfully entering or leaving the premises with evidence of forcible entry or exit?

- A) Robbery
- B) Burglary
- C) Safe burglary
- D) Extortion

Correct Answer: B) Burglary

Question 385

What is a fidelity bond used for in crime coverage?

- A) To cover losses from natural disasters
- B) To cover losses from employee theft or dishonesty
- C) To cover losses from unauthorized disclosure of confidential information
- D) To cover losses from nuclear hazards

Correct Answer: B) To cover losses from employee theft or dishonesty

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Question 386

Which of the following is NOT considered a "custodian" under crime coverage forms?

- A) An employee having care and custody of covered property inside the premises
- B) A watchperson
- C) The insured
- D) A partner of the insured

Correct Answer: B) A watchperson

Question 387

What type of loss is covered under "Inside the premises – theft of money and securities"?

- A) Loss of property from a safe or vault
- B) Theft, disappearance, or destruction of money while inside the insured premises or a banking premise
- C) Loss of property by actual or attempted robbery while outside the premises
- D) Losses resulting from forgery or alteration of checks

Correct Answer: B) Theft, disappearance, or destruction of money while inside the insured premises or a banking premise

Question 388

Which of the following is an exclusion under crime coverage?

- A) Theft committed by an employee
- B) Losses due to pollution
- C) Losses from computer fraud
- D) Losses from funds transfer fraud

Correct Answer: B) Losses due to pollution

Question 389

What is covered under "Computer fraud" in crime coverage?

- A) Theft of property directly related to the use of a computer to fraudulently cause a transfer from inside the premises to a person or place outside the premises
- B) Losses from unauthorized disclosure of confidential information
- C) Losses from nuclear hazards
- D) Losses from employee theft

Correct Answer: A) Theft of property directly related to the use of a computer to fraudulently cause a transfer from inside the premises to a person or place outside the premises

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Question 390

What is the limit of liability and deductible applied to in crime coverage?

- A) Per employee
- B) Per occurrence
- C) Per policy period
- D) Per claim

Correct Answer: B) Per occurrence

Question 391

What is the maximum amount an insurer will pay for loss or damage to property other than money and securities under crime coverage?

- A) The property's market value
- B) The property's replacement cost or the limit of insurance, whichever is less
- C) The property's original purchase price
- D) Twice the property's replacement cost

Correct Answer: B) The property's replacement cost or the limit of insurance, whichever is less

Question 392

How are losses to securities valued under crime coverage?

- A) At face value
- B) At market value at close of business on the day the loss was discovered
- C) At replacement cost
- D) At the original purchase price

Correct Answer: B) At market value at close of business on the day the loss was discovered

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Question 393

What is the coverage territory for crime coverage?

- A) Worldwide
- B) United States, its territories and possessions, Puerto Rico, and Canada
- C) North America only
- D) United States only

Correct Answer: B) United States, its territories and possessions, Puerto Rico, and Canada

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Question 394

Which of the following is NOT automatically covered for 90 days under crime coverage?

- A) New employees
- B) Additional premises obtained through a merger
- C) New equipment purchases
- D) Additional premises obtained through an acquisition

Correct Answer: C) New equipment purchases

Question 395

What is the primary difference between the Loss Sustained Form and the Discovery Form in crime coverage?

- A) The type of property covered
- B) The trigger for coverage
- C) The geographical coverage area
- D) The amount of deductible

Correct Answer: B) The trigger for coverage

Question 396

Which of the following is NOT covered by a Fidelity bond?

- A) Loss of cash due to employee theft
- B) Losses based solely on inventory shortages
- C) Loss of merchandise due to employee theft
- D) Loss of autos due to employee theft

Correct Answer: B) Losses based solely on inventory shortages

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Question 397

What is the role of the Surety in a Fidelity bond?

- A) The employee who is required to perform duties honestly
- B) The party who guarantees that the Principal will perform as agreed
- C) The employer who will be paid if the Principal fails to perform
- D) The party who initiates the bond

Correct Answer: B) The party who guarantees that the Principal will perform as agreed

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Question 398

Which type of professional liability insurance covers claims of negligence or inadequate work by professionals?

- A) Medical Malpractice
- B) Errors and Omissions (E&O)
- C) Directors and Officers (D&O)
- D) Employment Practices Liability (EPLI)

Correct Answer: B) Errors and Omissions (E&O)

Question 399

What does Cyber Liability insurance cover?

- A) Losses due to data breaches and cyberattacks
- B) Losses due to employee theft
- C) Losses due to natural disasters
- D) Losses due to equipment failure

Correct Answer: A) Losses due to data breaches and cyberattacks

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Question 400

Which of the following is an example of a situation where Liquor Liability insurance would be applicable?

- A) A bar is sued after a patron causes a car accident while intoxicated
- B) A restaurant is sued for food poisoning
- C) A hotel is sued for a slip and fall accident
- D) A retail store is sued for false advertising

Correct Answer: A) A bar is sued after a patron causes a car accident while intoxicated

Question 401

What does Professional Liability Insurance cover?

- A) Claims of theft or fraud in professional services
- B) Claims of negligence or errors in professional services
- C) Claims of property damage
- D) Claims of personal injury

Correct Answer: B) Claims of negligence or errors in professional services

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Question 402

Which professionals are particularly in need of Professional Liability Insurance?

- A) Retail workers
- B) Consultants, accountants, and lawyers
- C) Construction laborers
- D) Sales representatives

Correct Answer: B) Consultants, accountants, and lawyers

Question 403

Why is Professional Liability Insurance important for business professionals?

- A) It covers personal expenses
- B) It provides protection against lawsuits and financial security
- C) It guarantees business profits
- D) It covers travel expenses

Correct Answer: B) It provides protection against lawsuits and financial security

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Question 404

What does Directors and Officers Liability Insurance cover?

- A) Claims against company executives for decisions made while managing the business
- B) Claims of product defects
- C) Claims of environmental damage
- D) Claims of workplace injuries

Correct Answer: A) Claims against company executives for decisions made while managing the business

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Question 405

How can Directors and Officers Liability Insurance benefit a company?

- A) By reducing employee salaries
- B) By attracting and retaining top talent
- C) By increasing product sales
- D) By lowering utility costs

Correct Answer: B) By attracting and retaining top talent

Question 406

What type of claims does Employment Practices Liability Insurance cover?

- A) Claims of product liability
- B) Claims of discrimination, harassment, or wrongful termination
- C) Claims of copyright infringement
- D) Claims of breach of contract

Correct Answer: B) Claims of discrimination, harassment, or wrongful termination

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Question 407

Which industries are more susceptible to employment-related claims?

- A) Healthcare, hospitality, and retail
- B) Agriculture, mining, and fishing
- C) Manufacturing, construction, and transportation
- D) Education, arts, and entertainment

Correct Answer: A) Healthcare, hospitality, and retail

Question 408

Why is Employment Practices Liability Insurance important for businesses?

- A) It covers the cost of office supplies
- B) It helps cover legal fees, settlements, and damages from employment-related lawsuits
- C) It guarantees employee promotions
- D) It covers the cost of employee training

Correct Answer: B) It helps cover legal fees, settlements, and damages from employment-related lawsuits

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Question 409

What is a potential benefit of having Employment Practices Liability Insurance?

- A) It ensures higher employee turnover
- B) It provides coverage for public relations expenses to mitigate reputational damage
- C) It guarantees higher sales revenue
- D) It reduces the need for employee evaluations

Correct Answer: B) It provides coverage for public relations expenses to mitigate reputational damage

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Question 410

What is a common misconception about company indemnification provisions?

- A) They provide comprehensive coverage in the event of a lawsuit
- B) They are unnecessary for small businesses
- C) They are only applicable to large corporations
- D) They are more expensive than D&O insurance

Correct Answer: A) They provide comprehensive coverage in the event of a lawsuit

Question 411

What is the primary purpose of umbrella/excess liability insurance?

- A) To provide coverage for property damage
- B) To offer additional coverage beyond the limits of an underlying policy
- C) To replace primary liability policies
- D) To cover intentional acts

Correct Answer: B) To offer additional coverage beyond the limits of an underlying policy

Question 412

Which type of insurance typically follows the same terms and conditions as the underlying primary policy?

- A) Commercial umbrella insurance
- B) Commercial excess liability insurance
- C) Personal umbrella insurance
- D) Business Owners Policy (BOP)

Correct Answer: B) Commercial excess liability insurance

Question 413

What is a key difference between commercial umbrella insurance and commercial excess liability insurance?

- A) Umbrella insurance is only for personal use
- B) Excess liability insurance offers broader coverage
- C) Umbrella insurance may offer broader coverage
- D) Excess liability insurance is cheaper

Correct Answer: C) Umbrella insurance may offer broader coverage

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Question 414

Which of the following is NOT typically covered by a personal umbrella policy?

- A) Personal injury insurance
- B) Coverage for small watercraft
- C) Intentional acts
- D) Liability for a teenage driver

Correct Answer: C) Intentional acts

Question 415

What is the principle of indemnity in insurance?

- A) To ensure the insured profits from a claim
- B) To restore the insured to their financial position before the loss
- C) To provide unlimited coverage
- D) To cover all types of losses

Correct Answer: B) To restore the insured to their financial position before the loss

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Question 416

Which of the following best describes a moral hazard?

- A) A tangible condition increasing loss probability
- B) Indifference to loss due to insurance presence
- C) Reckless behavior due to having insurance
- D) A legal principle requiring financial interest

Correct Answer: C) Reckless behavior due to having insurance

Question 417

What is the Actual Cash Value (ACV) in loss valuation?

- A) The cost to replace an item without depreciation
- B) The market value of an item
- C) The value of an item considering depreciation
- D) The agreed value between insurer and insured

Correct Answer: C) The value of an item considering depreciation

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Question 418

Which of the following is an example of a physical hazard?

- A) An employee's indifference to loss
- B) An old, faulty electrical system
- C) A driver engaging in risky behavior
- D) A homeowner's financial interest in their house

Correct Answer: B) An old, faulty electrical system

Question 419

What is the purpose of a Business Owners Policy (BOP)?

- A) To provide coverage for large corporations
- B) To combine various coverages into a single policy for small to medium-sized businesses
- C) To offer unlimited liability coverage
- D) To cover only property damage

Correct Answer: B) To combine various coverages into a single policy for small to medium-sized businesses

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Question 420

What is insurable interest in the context of insurance?

- A) The chance of a loss occurring
- B) A condition increasing the likelihood of a loss
- C) A legal principle requiring a financial interest in the insured item
- D) The estimated resale value of an item after a total loss

Correct Answer: C) A legal principle requiring a financial interest in the insured item

Question 421

What is the definition of negligence in the context of insurance?

- A) The legal responsibility for damages caused to another party.
- B) The failure to exercise reasonable care, resulting in damage or injury to another party.
- C) An event or series of events that result in a loss or damage.
- D) A temporary insurance contract that provides coverage until a formal policy is issued.

Correct Answer: B) The failure to exercise reasonable care, resulting in damage or injury to another party.

Question 422

Which of the following best describes a binder in insurance terms?

- A) A document that provides evidence of insurance coverage.
- B) A temporary insurance contract that provides coverage until a formal policy is issued.
- C) A statistical principle that states that the larger the number of exposure units, the more predictable the losses become.
- D) A condition or promise in an insurance contract that must be met for coverage to be valid.

Correct Answer: B) A temporary insurance contract that provides coverage until a formal policy is issued.

Question 423

What is the primary purpose of a certificate of insurance?

- A) To provide a summary of the key details of the policy.
- B) To outline the duties and responsibilities of both the insured and the insurer.
- C) To provide evidence of insurance coverage.
- D) To list specific situations or perils that are not covered by an insurance policy.

Correct Answer: C) To provide evidence of insurance coverage.

Question 424

Which of the following is an example of pure risk?

- A) Investing in the stock market.
- B) The risk of a house fire.
- C) Starting a new business.
- D) Buying a lottery ticket.

Correct Answer: B) The risk of a house fire.

Question 425

What is the role of the declarations page in an insurance policy?

- A) It outlines the insurer's promise to pay for covered losses.
- B) It provides a summary of the key details of the policy.
- C) It lists specific situations or perils that are not covered.
- D) It details the duties and responsibilities of both the insured and the insurer.

Correct Answer: B) It provides a summary of the key details of the policy.

Question 426

What is the main difference between general and special damages?

- A) General damages compensate for specific monetary losses, while special damages compensate for non-monetary losses.
- B) General damages are awarded to punish the defendant, while special damages are for specific monetary losses.
- C) General damages compensate for non-monetary losses, while special damages compensate for specific monetary losses.
- D) General damages are temporary, while special damages are permanent.

Correct Answer: C) General damages compensate for non-monetary losses, while special damages compensate for specific monetary losses.

Question 427

What does the Law of Large Numbers state in the context of insurance?

- A) The larger the number of exposure units, the more unpredictable the losses become.
- B) The larger the number of exposure units, the more predictable the losses become.
- C) The smaller the number of exposure units, the more predictable the losses become.
- D) The smaller the number of exposure units, the more unpredictable the losses become.

Correct Answer: B) The larger the number of exposure units, the more predictable the losses become.

Question 428

What is the purpose of punitive damages?

- A) To compensate for non-monetary losses such as pain and suffering.
- B) To compensate for specific monetary losses such as medical bills and lost wages.
- C) To punish the defendant for egregious conduct and deter future misconduct.
- D) To provide temporary insurance coverage until a formal policy is issued.

Correct Answer: C) To punish the defendant for egregious conduct and deter future misconduct.

Question 429

What is concealment in the context of insurance?

- A) The intentional withholding of material information crucial for underwriting an insurance policy.
- B) A statement made by the insured during the application process that is believed to be true.
- C) A condition or promise in an insurance contract that must be met for coverage to be valid.
- D) A temporary insurance contract that provides coverage until a formal policy is issued.

Correct Answer: A) The intentional withholding of material information crucial for underwriting an insurance policy.

Question 430

What is an endorsement in an insurance policy?

- A) A document that provides evidence of insurance coverage.
- B) An addition or modification to an insurance policy that alters the coverage.
- C) A statistical principle that states that the larger the number of exposure units, the more predictable the losses become.
- D) A temporary insurance contract that provides coverage until a formal policy is issued.

Correct Answer: B) An addition or modification to an insurance policy that alters the coverage.

Question 431

What is the definition of the "insured" in an insurance policy?

- A) The person or entity that sells the insurance policy.
- B) The person or entity covered by an insurance policy.
- C) The company that underwrites the insurance policy.
- D) The broker who facilitates the purchase of the insurance policy.

Correct Answer: B) The person or entity covered by an insurance policy.

Question 432

In a homeowner's insurance policy, who is typically included as the insured?

- A) Only the policyholder.
- B) The policyholder and their family members living in the same household.
- C) Only the policyholder's children.
- D) Only the policyholder's spouse.

Correct Answer: B) The policyholder and their family members living in the same household.

Question 433

Which of the following is NOT typically considered a duty of the insured after a loss?

- A) Disclose material information.
- B) Avoid concealment and misrepresentation.
- C) Investigate the claim.
- D) Provide proof of loss to the insurer.

Correct Answer: C) Investigate the claim.

Question 434

What is the primary role of the insurer in an insurance policy?

- A) To sell the insurance policy.
- B) To cover the insured's claims under the policy.
- C) To act as a broker for the insured.
- D) To provide legal advice to the insured.

Correct Answer: B) To cover the insured's claims under the policy.

Question 435

Which of the following is a responsibility of an insurance company?

- A) To conceal information from the insured.
- B) To act in bad faith when handling claims.
- C) To fully investigate the insured's claim.
- D) To ignore communications from the insured.

Correct Answer: C) To fully investigate the insured's claim.

Question 436

What does a mortgagee clause in a property insurance policy do?

- A) Protects the homeowner from all types of damage.
- B) Ensures the insurance company pays the mortgage lender for losses.
- C) Allows the homeowner to cancel the insurance policy at any time.
- D) Provides additional coverage for personal belongings.

Correct Answer: B) Ensures the insurance company pays the mortgage lender for losses.

Question 437

Who is considered a named insured in an insurance policy?

- A) Anyone living in the same household as the policyholder.
- B) The person whose name specifically appears on the policy.
- C) Any domestic employees of the policyholder.
- D) Any students dependent on the policyholder.

Correct Answer: B) The person whose name specifically appears on the policy.

Question 438

Which of the following is NOT typically included in the definition of an insured living in the same household?

- A) The named insured's partner.
- B) Relatives of the named insured or their partner.
- C) Any domestic employees.
- D) Neighbors of the named insured.

Correct Answer: D) Neighbors of the named insured.

Question 439

What is the consequence if the insured fails to fulfill their duties after a loss?

- A) The policy is automatically renewed.
- B) The insured receives a bonus payment.
- C) The policy may be canceled, and premiums forfeited.
- D) The insurer must pay double the claim amount.

Correct Answer: C) The policy may be canceled, and premiums forfeited.

Question 440

What is the duty to defend in an insurance policy?

- A) The insurer's obligation to provide legal representation if the insured is sued.
- B) The insured's responsibility to defend the insurer in court.
- C) The broker's duty to defend the policy terms.
- D) The insured's obligation to defend their own claims.

Correct Answer: A) The insurer's obligation to provide legal representation if the insured is sued.

Question 441

What is the role of a mortgagor in a mortgage transaction?

- A) Lender
- B) Borrower
- C) Insurance provider
- D) Real estate agent

Correct Answer: B) Borrower

Question 442

Which of the following best describes a mortgagee clause?

- A) A clause that protects the borrower from foreclosure
- B) A clause that indemnifies the lender against property damage
- C) A clause that reduces the interest rate on a mortgage
- D) A clause that extends the mortgage term

Correct Answer: B) A clause that indemnifies the lender against property damage

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Question 443

What is an example of a situation where a mortgagee clause would be beneficial to the lender?

- A) The borrower pays off the mortgage early
- B) The property is damaged by a natural disaster
- C) The borrower refinances the mortgage
- D) The property value increases

Correct Answer: B) The property is damaged by a natural disaster

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Question 444

What is the primary purpose of a proof of loss form?

- A) To apply for a new insurance policy
- B) To formally notify the insurer of a claim
- C) To cancel an existing insurance policy
- D) To negotiate a lower insurance premium

Correct Answer: B) To formally notify the insurer of a claim

Question 445

Which of the following is NOT typically included in a proof of loss form?

- A) Date and time of the incident
- B) Evidence of the loss
- C) The insured's credit score
- D) Current property replacement value

Correct Answer: C) The insured's credit score

Question 446

What is a notice of claim?

- A) A request to increase insurance coverage
- B) A formal notification to the insurer that a loss has occurred
- C) A document that cancels an insurance policy
- D) A statement of the insured's financial status

Correct Answer: B) A formal notification to the insurer that a loss has occurred

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Question 447

In a mortgage transaction, who is the mortgagee?

- A) The borrower
- B) The lender
- C) The insurance company
- D) The real estate agent

Correct Answer: B) The lender

Question 448

What happens if a proof of loss form is incomplete?

- A) The insurer automatically approves the claim
- B) The insurer may refuse to process the form
- C) The claim is settled for a lower amount
- D) The insurer increases the premium

Correct Answer: B) The insurer may refuse to process the form

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Question 449

Which of the following is an example of a supplementary payment in an insurance policy?

- A) Premium refund
- B) Defense attorney fees
- C) Deductible waiver
- D) Policy renewal discount

Correct Answer: B) Defense attorney fees

Question 450

What is the difference between cancellation and nonrenewal of an insurance policy?

- A) Cancellation occurs at the end of the policy term, while nonrenewal can happen anytime
- B) Cancellation ends the policy before expiration, while nonrenewal is the decision not to renew at term end
- C) Cancellation is initiated by the insured, while nonrenewal is initiated by the insurer
- D) Cancellation increases the premium, while nonrenewal decreases it

Correct Answer: B) Cancellation ends the policy before expiration, while nonrenewal is the decision not to renew at term end

Question 451

When is a Notice of Insurance Claim appropriate?

- A) Only in cases of natural disasters
- B) In almost any case where someone else was at fault for your injuries
- C) Only for car accidents
- D) Only when the insurance company requests it

Correct Answer: B) In almost any case where someone else was at fault for your injuries

Question 452

What is the primary reason for sending a Notice of Insurance Claim as soon as possible after an injury?

- A) To ensure the insurance company has enough time to process the claim
- B) To make sure the incident details are fresh in your mind and correct
- C) To avoid paying higher premiums
- D) To receive immediate compensation

Correct Answer: B) To make sure the incident details are fresh in your mind and correct

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Question 453

Which of the following is NOT a key element to include in a Notice of Insurance Claim?

- A) Your contact information
- B) A detailed account of your financial status
- C) The date of the accident
- D) A brief description of the injuries sustained

Correct Answer: B) A detailed account of your financial status

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Question 454

What does the "Other Insurance Clause" in an insurance policy specify?

- A) The total amount of coverage available for a single policy
- B) How coverage will be apportioned if multiple insurance policies cover the same risk
- C) The deductible amount for each claim
- D) The premium payment schedule

Correct Answer: B) How coverage will be apportioned if multiple insurance policies cover the same risk

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Question 455

What is subrogation in the context of insurance?

- A) The process of an insurer paying out a claim
- B) The legal right held by insurers to pursue a third party that caused an insurance loss to the insured
- C) The method of calculating insurance premiums
- D) The act of canceling an insurance policy

Correct Answer: B) The legal right held by insurers to pursue a third party that caused an insurance loss to the insured

Question 456

Which of the following is an example of a loss settlement provision?

- A) Subrogation
- B) Actual Cash Value
- C) Other Insurance Clause
- D) Terrorism Risk Insurance Act

Correct Answer: B) Actual Cash Value

Question 457

What does the Terrorism Risk Insurance Act (TRIA) provide?

- A) A method for calculating insurance premiums
- B) A government backstop for insurance claims related to acts of terrorism
- C) A guideline for subrogation processes
- D) A standard for loss settlement provisions

Correct Answer: B) A government backstop for insurance claims related to acts of terrorism

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Question 458

What authority does the Georgia Insurance Commissioner have regarding insurance companies?

- A) To set insurance premium rates
- B) To regulate and oversee the insurance industry within the state
- C) To provide legal representation for policyholders
- D) To issue insurance policies directly

Correct Answer: B) To regulate and oversee the insurance industry within the state

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Question 459

How are insurance companies classified based on their origin of incorporation?

- A) Primary, Secondary, and Tertiary
- B) Local, National, and International
- C) Domestic, Foreign, and Alien
- D) Public, Private, and Government

Correct Answer: C) Domestic, Foreign, and Alien

Question 460

What is the difference between a stock insurance company and a mutual insurance company?

- A) Stock insurance companies are owned by policyholders, while mutual insurance companies are owned by shareholders
- B) Stock insurance companies are owned by shareholders, while mutual insurance companies are owned by policyholders
- C) Stock insurance companies are government-owned, while mutual insurance companies are privately owned
- D) Stock insurance companies only offer life insurance, while mutual insurance companies offer all types of insurance

Correct Answer: B) Stock insurance companies are owned by shareholders, while mutual insurance companies are owned by policyholders

Question 461

What is the primary responsibility of an insurance agent?

- A) Investigating and settling insurance claims
- B) Selling insurance products and assisting consumers with applications and enrollments
- C) Providing advice and information about insurance products without selling
- D) Arranging insurance coverage for risks that cannot be insured through standard markets

Correct Answer: B) Selling insurance products and assisting consumers with applications and enrollments

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Question 462

Which of the following is a reason for license revocation for an insurance agent?

- A) Completing continuing education requirements
- B) Engaging in fraudulent practices
- C) Holding a nonresident license
- D) Selling insurance in multiple states

Correct Answer: B) Engaging in fraudulent practices

Question 463

What is the purpose of a temporary insurance license?

- A) To allow agents to sell insurance in multiple states
- B) To provide coverage for high-risk properties
- C) To continue business operations while waiting for a permanent license
- D) To offer discounts on insurance premiums

Correct Answer: C) To continue business operations while waiting for a permanent license

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Question 464

What does rebating in the insurance industry involve?

- A) Offering something of value to induce the purchase or renewal of an insurance policy
- B) Making false statements about an individual or entity
- C) Charging unauthorized or hidden fees to policyholders
- D) Mixing an insured's funds with the agent's or insurer's funds

Correct Answer: A) Offering something of value to induce the purchase or renewal of an insurance policy

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Question 465

Which of the following is an example of unfair discrimination in insurance?

- A) Charging higher premiums based on actuarial justification
- B) Offering discounts for completing a defensive driving course
- C) Charging higher premiums to policyholders of a certain ethnicity without justification
- D) Providing coverage through the FAIR Plan

Correct Answer: C) Charging higher premiums to policyholders of a certain ethnicity without justification

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Question 466

What is the role of a surplus lines broker?

- A) Investigating and settling insurance claims
- B) Selling insurance products and assisting consumers
- C) Arranging insurance coverage for risks that cannot be insured through standard markets
- D) Providing advice and information about insurance products

Correct Answer: C) Arranging insurance coverage for risks that cannot be insured through standard markets

Question 467

What is the purpose of the Georgia Insurer Solvency Pool?

- A) To provide temporary insurance contracts
- B) To ensure insurers remain solvent and can meet their obligations
- C) To offer property insurance to those who cannot obtain coverage in the standard market
- D) To provide auto insurance to high-risk drivers

Correct Answer: B) To ensure insurers remain solvent and can meet their obligations

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Question 468

What is the FAIR Plan designed to do?

- A) Provide auto insurance to high-risk drivers
- B) Offer property insurance to those who cannot obtain coverage in the standard market
- C) Ensure insurers remain solvent
- D) Provide temporary insurance contracts

Correct Answer: B) Offer property insurance to those who cannot obtain coverage in the standard market

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Question 469

What is the purpose of uninsured motorist coverage?

- A) To provide discounts for completing a defensive driving course
- B) To protect policyholders in the event of an accident with an uninsured driver
- C) To ensure insurers remain solvent
- D) To offer property insurance to high-risk properties

Correct Answer: B) To protect policyholders in the event of an accident with an uninsured driver

Question 470

What does the Financial Responsibility Law require from drivers?

- A) To complete a defensive driving course
- B) To have insurance or other financial responsibility to cover damages in case of an accident
- C) To provide coverage through the FAIR Plan
- D) To obtain a nonresident license

Correct Answer: B) To have insurance or other financial responsibility to cover damages in case of an accident

Summary Of Georgia State Laws, Rules, And Regulations Pertinent To All Insurance Lines

Here is a summary of Georgia state law sections 33-2-1 through 33-2-6:

Section 33-2-1: Establishes the Department of Insurance in Georgia and designates the Commissioner of Insurance as the chief officer. It outlines the general powers and duties of the department and the Commissioner[1].

Section 33-2-2: Describes the official seal of the Commissioner of Insurance, which is used to authenticate documents issued by the department[2].

Section 33-2-3: Details the appointment and qualifications of the Commissioner of Insurance, including the requirement that the Commissioner must be a resident of Georgia[3].

Section 33-2-4: Specifies the oath of office that the Commissioner must take before assuming duties[3].

Section 33-2-5: Outlines the bond requirements for the Commissioner, ensuring they are financially accountable for their actions[3].

Section 33-2-6: Provides for the appointment of a Deputy Commissioner and other staff, detailing their roles and responsibilities[3].

These sections collectively establish the framework for the Department of Insurance in Georgia, defining the roles, responsibilities, and requirements for the Commissioner and their staff.

Here is a summary of Georgia state law sections 33-2-9 through 33-2-32:

Section 33-2-9: Grants the Commissioner the authority to make rules and regulations necessary to implement the insurance laws, organize the department, and ensure compliance with federal laws like the Health Insurance Portability and Accountability Act (HIPAA)[1].

Section 33-2-10: Requires the Commissioner to maintain records of all proceedings, hearings, investigations, and other official actions[1].

Section 33-2-11: Allows the Commissioner to conduct investigations and examinations of insurance matters and entities to ensure compliance with the law[1].

Section 33-2-12: Provides the Commissioner with the power to subpoena witnesses, administer oaths, and compel the production of documents during investigations[1].

Section 33-2-13: Details the procedures for hearings conducted by the Commissioner, including notice requirements and the right to a fair hearing[1].

Section 33-2-14: Outlines the process for judicial review of the Commissioner's orders and decisions[1].

Section 33-2-15: Specifies the penalties for violating insurance laws or regulations, including fines and license revocation[1].

Section 33-2-16: Establishes the Commissioner's authority to issue cease and desist orders to prevent unlawful insurance practices[1].

Section 33-2-17: Allows the Commissioner to seek injunctions from the courts to enforce compliance with insurance laws[1].

Section 33-2-18: Provides for the confidentiality of certain records and information obtained by

the Commissioner during investigations[1].

Section 33-2-19: Requires the Commissioner to report annually to the Governor and the General Assembly on the state of the insurance industry in Georgia[1].

Section 33-2-20: Details the Commissioner's authority to regulate insurance rates and ensure they are not excessive, inadequate, or unfairly discriminatory[1].

Section 33-2-21: Establishes the procedures for the approval or disapproval of insurance policy forms and endorsements[1].

Section 33-2-22: Provides the Commissioner with the authority to regulate insurance advertising to prevent misleading or deceptive practices[1].

Section 33-2-23: Outlines the requirements for the licensing of insurance agents, brokers, and other intermediaries[1].

Section 33-2-24: Specifies the continuing education requirements for licensed insurance professionals[1].

Section 33-2-25: Details the procedures for the suspension or revocation of insurance licenses[1].

Section 33-2-26: Establishes the Commissioner's authority to regulate insurance companies' financial solvency and ensure they maintain adequate reserves[1].

Section 33-2-27: Provides for the examination of insurance companies' books and records to ensure compliance with financial regulations[1].

Section 33-2-28: Outlines the procedures for the rehabilitation or liquidation of insolvent insurance companies[1].

Section 33-2-29: Details the requirements for the filing of annual financial statements by insurance companies[1].

Section 33-2-30: Establishes the Commissioner's authority to regulate reinsurance transactions[1].

Section 33-2-31: Provides for the regulation of insurance holding companies and their subsidiaries[1].

Section 33-2-32: Details the procedures for the approval of mergers and acquisitions involving insurance companies[1].

These sections collectively provide a comprehensive framework for the regulation of the insurance industry in Georgia, ensuring that the Commissioner has the necessary authority to enforce compliance and protect consumers.

Insurance Department and Commissioner

Here is a summary of Georgia state law sections 33-2-10 through 33-2-13:

Section 33-2-10: This section outlines the issuance and service of orders and notices by the Commissioner of Insurance. Orders and notices must be in writing, signed by the Commissioner or by their authority, and must state their effective date, intent, purpose, and the grounds on which they are based[1].

Section 33-2-11: This section grants the Commissioner the authority to examine insurers and other related organizations to ensure compliance with insurance laws. It also covers the procedures for such examinations[1].

Section 33-2-12: This section allows the Commissioner to examine agents, solicitors, brokers, counselors, adjusters, managers, and promoters. It details the scope and procedures of these examinations[1].

Section 33-2-13: This section provides the Commissioner with access to records during examinations. It also allows the Commissioner to correct inadequate or incorrect accounts, and if necessary, employ experts to rewrite, post, or balance such records at the expense of the person being examined[2].

These sections collectively ensure that the Commissioner has the necessary authority to oversee and regulate the insurance industry in Georgia effectively.

Here are the summaries for Georgia state laws 33-6-6 and 33-6-9:

Georgia State Law 33-6-6

This law grants the Commissioner of Insurance the authority to examine and investigate the affairs of any person engaged in the insurance business within the state. The purpose is to determine if they are involved in any unfair competition or deceptive practices. The Commissioner can also require reports to be filed in specific formats to facilitate these investigations[1].

Georgia State Law 33-6-9

This law outlines the penalties for violating cease and desist orders issued by the Commissioner of Insurance. If a person violates such an order, they may face a monetary penalty of up to $10,000 for each violation, suspension or revocation of their license, or any other reasonable and appropriate relief as determined by the Commissioner[2].

General Insurance Definitions

Here are the summaries for General Insurance Definitions: Georgia State Law 33-3-1

This section provides definitions for terms used in Chapter 3, such as “administrative supervision,” “alien insurer,” “domestic insurer,” and "foreign insurer"[1].

Georgia State Law 33-14-2

This law defines “mutual insurer” as an incorporated insurer without capital stock owned by its policyholders, and “stock insurer” as an incorporated insurer with capital divided into shares owned by its shareholders[2].

Georgia State Law 33-3-2 through 33-3-5

33-3-2: Requires a certificate of authority for any insurer to transact insurance within the state, with certain exceptions[3].

33-3-3: Outlines the qualifications necessary for an insurer to transact insurance in Georgia, including compliance with state laws and charter powers[4].

33-3-4: Specifies the kinds of insurance that insurers may transact[3].

33-3-5: Classifies the types of insurance into six categories: life, accident, and sickness; property, marine, and transportation; casualty; surety; title; and health maintenance organization[5].

Georgia State Law 33-3-13 through 33-13-30

33-3-13: Addresses the requirements for insurers to maintain certain levels of capital and

surplus[3].

33-13-30: Declares that the Own Risk and Solvency Assessment Summary Report contains confidential and sensitive information, which is not subject to public disclosure[6].

Licensing of Agents, Counselors, Subagents, and Adjusters

Georgia State Law 33-23-1 through 33-23-46

This section of the Georgia Code pertains to the **licensing of insurance agents, agencies, subagents, counselors, and adjusters**.

Key points include:

Definitions: Terms like “adjuster,” “agency,” “agent,” and “business entity” are defined to clarify roles and responsibilities[1].

Licensing Requirements: Specifies the qualifications, application process, and renewal requirements for obtaining and maintaining licenses for various insurance roles[1].

Compensation and Disclosure: Details the rules regarding compensation for licensed counselors, including the need for documented acknowledgment and disclosure of compensation from insurers or third parties[2].

Insurance Rules and Regulations 120-2-3-.09 and 120-2-3-.15

These regulations are part of the rules set by the Georgia Insurance Commissioner:

120-2-3-.09 (Examinations): Outlines the examination requirements for resident applicants seeking licensure under Chapter 23 of Title 33. It includes exceptions and specific conditions under which applicants must submit to examinations[3].

120-2-3-.15 (Continuing Education): Specifies the continuing education requirements for adjuster licensees. It mandates ongoing

Unfair Trade Practices

Here are the summaries of Unfair Trade Practices: Georgia State Law 33-6-4

This law enumerates **unfair methods of competition and unfair or deceptive acts or practices** in the business of insurance. It includes practices such as false advertising, misrepresentation of policy terms, and making misleading statements about an insurer’s financial condition[12].

Georgia State Law 33-6-5

This law addresses **other unfair methods of competition and unfair and deceptive acts or practices** not covered in 33-6-4. It prohibits practices like issuing insurance policies as an inducement to purchase property and using names that deceptively imply the person is an insurer[34].

Georgia State Law 33-9-36

This law prohibits **unauthorized premiums and unlawful inducements**. It states that brokers or agents cannot charge premiums not in accordance with the chapter and prohibits offering rebates, discounts, or other inducements not specified in the policy[56].

Georgia State Law 33-23-1

This section provides **definitions** for terms used in the licensing of insurance agents, agencies,

subagents, counselors, and adjusters. It clarifies roles such as “adjuster,” “agency,” and "agent"[78].

Georgia State Law 33-23-35

This law outlines the **reporting and disposition of premiums**. It requires agents and subagents to report premiums to the insurer and prohibits commingling of these funds with personal funds. Violations can result in misdemeanors or felonies depending on the amount involved[910].

Georgia State Law 33-24-7

This law states that **statements and descriptions in insurance applications** are deemed representations and not warranties.

Misrepresentations or omissions do not prevent recovery under the policy unless they are fraudulent, material to the risk, or would have affected the insurer’s decision to issue the policy[1112].

Advertising

Definition: Insurance advertising must be truthful and not misleading.

Example: An insurer cannot advertise a policy as “full coverage” if it has significant exclusions.

GA Code § 33-6-4 (2021)

As used in this Code section, the term:

"Gift certificate" shall have the same meaning as provided in Code Section 10-1-393.

"Policy" means any insuring bond issued by an insurer.

"Store gift card" shall have the same meaning as provided in Code Section 10-1-393.

The following acts or practices are deemed unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

Making, publishing, disseminating, circulating, or placing before the public or causing directly or indirectly to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or in any other way an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which statement, assertion, or representation is untrue, deceptive, or misleading;

Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued, the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; making any misleading representation or any misrepresentation as to the financial condition of any insurer, as to the legal reserve system upon which any life insurer operates; using any name or title of any policy or class of policies misrepresenting the true nature thereof; or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, or surrender his insurance. A dividend estimate prepared on company forms and clearly indicating, in type equal in size to that used in figures showing amounts of estimated dividends, that the dividends are based on estimates made by the company based upon past

experience of the company shall not be considered misrepresentation and false advertising within the meaning of this paragraph;

Making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false or maliciously critical of or substantially misrepresents the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance;

Entering into any agreement to commit or by any concerted action committing any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the business of insurance;

Filing with any supervisory or other public official or making, publishing, disseminating, circulating, delivering to any person, or placing before the public or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with the intent to deceive;

Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs or any public official to whom such insurer is required by law to report or who has authority by law to examine into its condition or into any of its affairs or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of the insurer;

Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency or company stock or other capital stock, benefit certificates or shares in any common-law corporation, securities, or any special or advisory board contracts of any kind promising returns and profits as an inducement to insurance;

Making or permitting any unfair discrimination between individuals of the same class, same policy amount, and equal expectation of life in the rates charged for any contract of life insurance or of life annuity, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or sickness insurance, in the benefits payable thereunder, in any of the terms or conditions of the contract, or in any other manner whatever.

Making or permitting any unfair discrimination in the issuance, renewal, or cancellation of any policy or contract of insurance against direct loss to residential property and the contents thereof, in the amount of premium, policy fees, or rates charged for the policies or contracts when the discrimination is based solely upon the age or geographical location of the property within a rated fire district without regard to objective loss experience relating thereto.

(I) Unfair discrimination prohibited by the provisions of this subparagraph includes discrimination based on race, color, and national or ethnic origin. In addition, in connection with any kind of insurance, it shall be an unfair and deceptive act or practice to refuse to insure or to refuse to continue to insure an individual; to limit the amount, extent, or kind of coverage available to an individual; or to charge an individual a different rate for the same coverage because of the race, color, or national or ethnic origin of that individual. The prohibitions of this division are in addition to and supplement any and all other provisions of Georgia law prohibiting such discrimination which were previously enacted and currently exist, or which may be enacted subsequently, and

shall not be a limitation on such other provisions of law.

A violation of this division shall give rise to a civil cause of action for damages resulting from such violation including, but not limited to, all damages recoverable for breach of insuring agreements under Georgia law including damages for bad faith and attorney's fees and costs of litigation.

A violation of this division shall also give rise to the awarding of punitive or exemplary damages in an amount as may be determined by the trier of fact if such violation is found to be intentional. The remedies provided in this division are in addition to and cumulative of all other remedies that may now or hereafter be provided by law.

Knowingly permitting or offering to make or making any contract of insurance or agreement as to the contract other than as plainly expressed in the contract issued thereon; paying, allowing, giving, or offering to pay, allow, or give directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract, except in accordance with an applicable rate filing, rating plan, or rating system filed with and approved by the Commissioner; giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such insurance or in connection therewith any stocks, bonds, or other securities of any company, any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract; or receiving or accepting as inducement to contracts of insurance any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.

Nothing in subparagraphs (A) and (B) of this paragraph shall be construed as including within the definition of discrimination or rebates any of the following practices:

In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the company and its policyholders;

In the case of life or accident and sickness insurance policies issued on the industrial debit or weekly premium plan, making allowance in an amount which fairly represents the saving in collection expense to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer;

Making a readjustment of the rate of premium for a policy based on the loss or expense experienced at the end of the first or any subsequent policy year of insurance thereunder, which adjustment may be made retroactive only for the policy year;

Issuing life or accident and sickness insurance policies covering bona fide employees of the insurer at a rate less than the rate charged other persons in the same class;

Issuing life or accident and sickness policies on a salary-saving, payroll deduction, preauthorized, postdated, automatic check, or draft plan at a reduced rate commensurate with the savings made by the use of such plan;

Paying commissions or other compensation to duly licensed agents or brokers or allowing or returning dividends, savings, or unabsorbed premium deposits to participating policyholders, members, or subscribers;

Paying by an insurance agent of part or all of the commissions on public insurance to a nonprofit

association of insurance agents which is affiliated with a recognized state or national insurance agents' association, which commissions are to be used in whole or in part for one or more civic enterprises;

Paying for food or refreshments by an insurer or an agent, broker, or employee of an insurer for current or prospective clients during group sales presentations and group seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars;

Paying for business meals and entertainment by an insurer or an agent, broker, or employee of an insurer, agent, or broker for current or prospective clients; or

Advertising or conducting promotional programs by insurers or insurance producers whereby prizes, goods, wares, store gift cards, gift certificates, sporting event tickets, or merchandise, not exceeding $100.00 in value per customer in the aggregate in any one calendar year, are given to current or prospective customers; provided, however, that the giving of any item or items of value under this subsection shall not be contingent on the sale or renewal of a policy;

Failing to instruct and require properly that agents shall, in the solicitation of insurance and the filling out of applications of insurance on behalf of policyholders, incorporate therein all material facts relevant to the risk being written, which facts are known to the agent or could have been known by proper diligence;

Encouraging agents to accept applications which contain material misrepresentations or conceal material information which, if stated in the application, would prevent issuance of the policy or which would void a policy from its inception according to its terms even though premiums had been paid on the policy;

Any insurer or agent of same becoming a party to requiring or imposing as a condition to the sale of real or personal property or to the financing of real or personal property, as a condition to the granting of or an extension of a loan which is to be secured by the title to or a lien of any kind on real or personal property, or as a condition to the performance of any other act in connection with the sale, financing, or lending, whether the person thus acts for himself or for anyone else, that the insurance or any renewal thereof to be issued on said property as collateral to said sale or loan shall be written through any particular insurance company or agent, provided that this paragraph shall not apply to a policy purchased by the seller, financier, or lender from his or its own funds and not charged to the purchaser or borrower in the sale price of the property or the amount of the loan or required to be paid for out of his personal funds; provided, further, that such seller, financier, or lender may disapprove for reasons affecting solvency or other sensible and sufficient reasons, the insurance company selected by the buyer or borrower. This paragraph shall not apply to title insurance;

Representing that any insurer or agent is employed by or otherwise associated with any medicare program as defined in Code Section 33-43-1 or the United States Social Security Administration or that any insurance policy sold or offered for sale has been endorsed or sponsored by the federal or state government.

Knowingly selling or offering to sell medicare supplement insurance coverage as defined in Code Section 33-43-1 which is not in compliance with the provisions of Chapter 43 of this title, relating to medicare supplement insurance, or the rules and regulations promulgated by the Commissioner pursuant to Chapter 43 of this title.

Representing that any individual policy is a group policy or that the insurer, agent, or policy is endorsed, sponsored by, or associated with any group, association, or other organization unless

such is, in fact, the case.

Knowingly selling to Medicaid recipients substantially unnecessary coverage which duplicates benefits provided under the Medicaid program without disclosing to the prospective buyer that it may not be to the buyer's benefit or that it might actually be to the buyer's detriment to purchase the additional coverage;

Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group life insurance policy in which computation of the death benefit is of such a technical nature that such death benefit cannot reasonably be properly presented in the advertisement and understood by a member of the insuring public. Policies, other than variable life or other interest sensitive policies, which provide for multiple changes in death benefits, combinations of increasing and nonuniformly decreasing term insurance, or increasing life insurance benefits equal to or slightly greater than the premiums paid during the early years of the coverage combined with accidental death benefits are types of contracts within the purview of this subparagraph. Additionally, any life insurance policy which cannot be truthfully, completely, clearly, and accurately disclosed in an advertisement falls within this subparagraph.

Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy which is misleading in fact or by implication that the coverage is "guaranteed issue" when there are conditions to be met by those persons to be insured, such as limited medical questions or other underwriting guidelines of the insurer.

Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy where such advertisement has not been approved for use in this state by the Commissioner;

Failing to disclose in printed advertising material that medical benefits are calculated on the basis of usual, customary, and reasonable charges;

(14.1) Engaging in dishonest, unfair, or deceptive insurance practices in marketing or sales of insurance to service members of the armed forces of the United States and, notwithstanding any other provision of this title, the Commissioner may promulgate such rules and regulations as necessary to define dishonest, unfair, or deceptive military marketing and sales practices;

(14.2) Failing to submit all claims data to the Georgia All-Payer Claims Database as required in Article 3 of Chapter 53 of Title 31;

(14.3) (A) As used in this paragraph:

No insurer shall require an ophthalmologist or optometrist to accept as payment an amount set by such insurer for services that are not covered eye care services under the covered person's eye care benefit plan as a condition to join or participate in its provider network.

No insurer shall draft, publish, disseminate, or circulate any explanations of benefit forms that include language that directly or indirectly states or implies that an ophthalmologist or optometrist should extend discounts to patients for noncovered eye care services.

No insurer shall require an ophthalmologist or optometrist within its provider network to extend any discounts on services that are not covered eye care services; or

As used in this paragraph, the term:

"Confidential abuse information" means information about acts of family violence or sexual assault, the status of a victim of family violence or sexual assault, an individual's medical

condition that the insurer knows or has reason to know is related to family violence or sexual assault, or the home and work addresses and telephone numbers of a subject of family violence or sexual assault.

"Family violence" means family violence as defined in Code Sections 19- 13-1 and 19-13-20 and as limited by Code Section 19-13-1.

"Sexual assault" means rape, sodomy, aggravated sodomy, sexual battery, and aggravated sexual battery as those terms are defined in Chapter 6 of Title 16.

No person shall deny or refuse to accept an application; refuse to insure; refuse to renew; refuse to reissue; cancel, restrict, or otherwise terminate; charge a different rate for the same coverage; add a premium differential; or exclude or limit coverage for losses or deny a claim incurred by an insured on the basis that the applicant or insured is or has been a victim of family violence or sexual assault or that such person knows or has reason to know the applicant or insured may be a victim of family violence or sexual assault; nor shall any person take or fail to take any of the aforesaid actions on the basis that an applicant or insured provides shelter, counseling, or protection to victims of family violence or sexual assault.

No person shall request, directly or indirectly, any information the person knows or reasonably should know relates to acts of family violence or sexual assault or an applicant's or insured's status as a victim of family violence or sexual assault or make use of such information however obtained, except for the limited purpose of complying with legal obligations, verifying an individual's claim to be a subject of family violence or sexual assault, cooperating with a victim of family violence or sexual assault in seeking protection from family violence or sexual assault, or facilitating the treatment of a family violence or sexual assault related medical condition.

When a person has information in their possession that clearly indicates that the insured or applicant is a subject of family violence or sexual assault, the disclosure or transfer of the information by a person to any person, entity, or individual is a violation of this Code section, except:

To the subject of family violence or sexual assault or an individual specifically designated in writing by the subject of family violence or sexual assault;

To a health care provider for the direct provision of health care services;

To a licensed physician identified and designated by the subject of family violence or sexual assault;

When ordered by the Commissioner or a court of competent jurisdiction or otherwise required by law;

When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed pursuant to this division only to the following persons or entities, all of whom shall be bound by this subparagraph:

A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of family violence or sexual assault and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

A party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the person;

Medical or claims personnel contracting with the person, only where necessary to process an

application or perform the person's duties under the policy or to protect the safety or privacy of a subject of family violence or sexual assault; or

With respect to address and telephone number, to entities with whom the person transacts business when the business cannot be transacted without the address and telephone number;

To an attorney who needs the information to represent the person effectively, provided the person notifies the attorney of its obligations under this paragraph and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the person;

To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about family violence or sexual assault status; or

To any other entities deemed appropriate by the Commissioner.

It is unfairly discriminatory to terminate group coverage for a subject of family violence because coverage was originally issued in the name of the perpetrator of the family violence and the perpetrator has divorced, separated from, or lost custody of the subject of family violence, or the perpetrator's coverage has terminated voluntarily or involuntarily. If termination results from an act or omission of the perpetrator, the subject of family violence shall be deemed a qualifying eligible individual under Code Section 33-24-21.1 and may obtain continuation and conversion of such coverages notwithstanding the act or omission of the perpetrator.

A person may request and receive confidential abuse information to implement the continuation and conversion of coverages under this subparagraph.

Subparagraph (C) of this paragraph shall not preclude a subject of family violence or sexual assault from obtaining his or her insurance records.

Subparagraph (C) of this paragraph shall not prohibit a person from asking about a medical condition or a claims history or from using medical information or a claims history to underwrite or to carry out its duties under the policy to the extent otherwise permitted under this paragraph and other applicable law.

No person shall take action that adversely affects an applicant or insured on the basis of a medical condition, claim, or other underwriting information that the person knows or has reason to know is family violence or sexual assault related and which:

Has the purpose or effect of treating family violence or sexual assault status as a medical condition or underwriting criterion;

Is based upon correlation between a medical condition and family violence or sexual assault;

Is not otherwise permissible by law and does not apply in the same manner and to the same extent to all applicants and insureds similarly situated without regard to whether the condition or claim is family violence or sexual assault related; or

Except for claim actions, is not based on a determination, made in conformance with sound actuarial and underwriting principles and guidelines generally applied in the insurance industry and supported by reasonable statistical evidence, that there is a correlation between the applicant's or insured's circumstances and a material increase in insurance risk.

No person shall fail to pay losses arising out of family violence or sexual assault against an innocent first-party claimant to the extent of such claimant's legal interest in the covered property, if the loss is caused by the intentional act of an insured against whom a family violence or sexual assault complaint is brought for the act causing this loss.

No person shall use other exclusions or limitations on coverage which the Commissioner has determined through the policy filing and approval process to unreasonably restrict the ability of victims of family violence or sexual assault to be indemnified for such losses.

Any person violating this Code section by making unlawful, false representations as to the policy sold shall be guilty of a misdemeanor.

"Covered eye care services" means those health care services and materials related to the care of the eye and related structures and vision care services for which a health care insurer is obligated to pay for or provide to covered persons under an eye care benefit plan, which includes services for which reimbursement is available under such plan, or for which reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

"Covered person" means any subscriber, enrollee, member, beneficiary, or participant, or his or her dependent, for whom benefits are payable when such person receives eye care services rendered or authorized by an ophthalmologist licensed under Chapter 34 of Title 43 or an optometrist licensed under Chapter 30 of Title 43.

"Eye care benefit plan" means any individual or group plan, policy contract, or subscription agreement which includes or is for eye care services that is issued, delivered, issued for delivery, or renewed in this state whether by a health care insurer, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical or eye care service corporation, health care plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes eye care services to patients, insureds, beneficiaries, or covered dependents in this state.

"Health care insurer" or "insurer" means an entity, including but not limited to insurance companies, health care corporations, health maintenance organizations, and preferred provider organizations, authorized by the state to offer or provide health benefit plans, eye care benefit plans, programs, policies, subscriber contracts, or any other agreements of a similar nature which compensate or indemnify health care providers for furnishing covered eye care or other health care services.

(l) Any person issuing, delivering, or renewing a policy of insurance in this state at any time shall include with such policy or renewal certificate a notice attached thereto containing the following language:

"NOTICE

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence."

Summary Of Georgia Rules And Codes Pertinent To Property & Casualty Insurance

Summary of Georgia Insurance Commissioner Rules & Regulations 120-2-53.01 through 120-2-53.06

These regulations pertain to the **cancellation and nonrenewal of insurance policies**:

120-2-53-.01 (Authority): Establishes the authority of the Commissioner of Insurance to promulgate these regulations under O.C.G.A. § 33-24-45[1].

120-2-53-.02 (Purpose): Defines the purpose of these regulations, which is to set notice

requirements for cancellations and nonrenewals and to provide procedures for review by the Commissioner[2].

20-2-53-.03 (Notice Requirements for Cancellations and Nonrenewals): Specifies the content and format of notices that insurers must provide to policyholders when canceling or nonrenewing policies. It includes the right of the insured to request a review by the Commissioner if they believe the cancellation or nonrenewal is unlawful[2].

120-2-53-.04 (Procedures for Review): Outlines the procedures for policyholders to request a review of cancellations or nonrenewals by the Commissioner[2].

120-2-53-.05 (Exceptions): Lists exceptions to the notice requirements, such as policies canceled for nonpayment of premiums[2].

120-2-53-.06 (Severability): States that if any part of these regulations is found invalid, the remaining sections will still be in effect[2].

Summary of Georgia State Law 33-24-44 through 33-24-47 These sections cover various aspects of **policy cancellations and nonrenewals**:

33-24-44 (Cancellation by Insurer): Details the conditions under which an insurer can cancel a policy, including nonpayment of premiums and material misrepresentation[3].

33-24-45 (Cancellation or Nonrenewal of Automobile or Motorcycle Policies): Specifies the procedures for canceling or nonrenewing auto or motorcycle insurance policies, including notice requirements and the right to a review by the Commissioner[4].

33-24-46 (Cancellation or Nonrenewal of Certain Property Insurance Policies): Covers the cancellation or nonrenewal of property insurance policies, including the notice period and the insured's right to request a review[5].

33-24-47 (Notice Required of Termination or Nonrenewal, Increase in Premium Rates, or Change Restricting or Reducing Coverage): Requires insurers to provide notice to policyholders of termination, nonrenewal, or significant premium increases. It also outlines the policyholder's right to an additional 30-day coverage period if the insurer fails to comply with notice requirements[4].

Cancellation and Nonrenewal of Policies References: 120-2-53-.01 through .06, 33 24-44 through 47

Summary: These regulations outline the requirements for notice and procedures for cancellation and nonrenewal of insurance policies in Georgia.

Subject 120-2-53 CANCELLATION AND NONRENEWAL REGULATION

Rule 120-2-53-.01 Authority

This Regulation made and promulgated by the Commissioner of Insurance pursuant to the authority set forth in O.C.G.A. § 33-24-45.

Rule 120-2-53-.02 Purpose

The purpose of this Regulation is to establish the notice requirements an insurer shall include in the notice of cancellation or notice of nonrenewal sent to an insured and to provide for procedures for a review by the Commissioner when an insured believes his or her policy has been canceled or nonrenewed in violation of O.C.G.A. § 33-24-45.

Rule 120-2-53-.03 Notice Requirements for Cancellations and Nonrenewals

Each notice of cancellation or nonrenewal shall include the following:

Each notice of nonrenewal, except for those exceptions contained within these rules, shall advise the insured of the opportunity of review of the nonrenewal by the Commissioner, as set forth herein, if the insured believes that his or her policy has been nonrenewed in violation of O.C.G.A. § 33-24-

45. Notice in the following form shall satisfy the notice requirement in

O.C.G.A. § 33-24-45(e)(5)(B) and serve to notify the insured of his or her opportunity for review of the nonrenewal. This notice shall only be used for nonrenewals.

NOTICE OF NONRENEWAL

"Code Section 33-24-45 of the Official Code of Georgia Annotated provides that this insurer must upon request, furnish you with the reasons for the failure to renew this policy. If you wish to assert that the nonrenewal is unlawful, you must file a written notice with this insurer before the time at which the nonrenewal becomes effective. The notice must specify the manner in which the failure to renew is alleged to be unlawful.

If you do not file the written notice, you may not later assert a claim or action against this insurer based upon an unlawful nonrenewal.

Additionally, within fifteen (15) days of receipt of this Notice of Nonrenewal, you may mail or deliver a written request for a review of the nonrenewal by the Commissioner if you believe your policy has been nonrenewed in violation of O.C.G.A. § 33-24-45. Your request must state the reasons why you believe the nonrenewal is in violation of O.C.G.A. § 33-24-45(e).

Each notice of cancellation, except for those exceptions contained within these rules, shall advise the insured of his or her opportunity to request, in writing, a review of the cancellation by the Commissioner, as set forth herein, if the insured believes that his or her policy has been canceled in violation of O.C.G.A. § 33-24-45. This notice shall only be used in the case of cancellation. Such cancellation notice to the insured shall be in substantially the following form:

NOTICE OF CANCELLATION

Within fifteen (15) days of receipt of this Notice of Cancellation, you may mail or deliver a written request for a review of the cancellation by the Commissioner if you believe your policy has been canceled in violation of

O.C.G.A. § 33-24-45(c). Your request must state the reasons why you feel the cancellation is in violation of this Code Section.

The notice of cancellation or nonrenewal shall specifically state any and all reasons for such cancellation or nonrenewal in clear, easy to understand language.

The notice of cancellation or nonrenewal shall specifically state the tender of premium requirements contained in Rule 120-2-53-.04.

The notice required by this rule shall not be mandated for policies canceled in compliance with O.C.G.A. § 33-24-45(c)(1) or those canceled in compliance with O.C.G.A. § 33-24-45(k).

No request for a review by the Commissioner shall be valid unless a written request is delivered or mailed with sufficient postage to the Commissioner within fifteen (15) days after receipt by the insured of the notice of cancellation or nonrenewal. A post office receipt of mailing to the named insured, at the insured's last known address according to the policy records, shall be conclusive proof of receipt of notice by the named insured on the fourth calendar day after mailing.

Rule 120-2-53-.04 Tender of Premiums During Period of Review, Refund of Premiums

During this period of review of the cancellation or nonrenewal, the insured shall tender to, and the insurer shall accept, a 30 day pro rata portion of the premiums applicable to the policy at the time the cancellation or nonrenewal is issued. The insured shall submit proof of such tender of premium as a part of the request for review by the Commissioner.

Rule 120-2-53-.05 Disposition and Penalties

If the Commissioner determines the cancellation or nonrenewal is lawful, termination under the policy shall be effective as of the date and time originally set forth under the notice of cancellation or nonrenewal.

Termination of the interim coverage provided pursuant to O.C.G.A. § 33-24- 45(o) during the pendency of the Commissioner's review shall not be effective less than five (5) days following the date of the Commissioner's decision. The Commissioner's decision shall establish the effective date of the termination of the interim coverage provided during the review of the cancellation or nonrenewal and shall serve as the official notice of termination of coverage referenced in O.C.G.A. § 33-24-45(e)(1).

In the event that the cancellation or nonrenewal is upheld by the Commissioner,

the insurer shall retain that portion of the pro rata premiums tendered for the period of time beginning with the original date of cancellation or nonrenewal and ending with the date of the termination of the interim coverage as established by the Commissioner pursuant to Rule 120- 2-53-.05(1); and

the insurer shall refund all remaining premiums to the insured within ten (10) working days of receipt of the Commissioner's decision establishing the effective date of the termination of the interim coverage.

A penalty may be assessed against the insurer in all cases where the Commissioner has determined that the cancellation or nonrenewal was not lawful. If the Commissioner makes such a determination, the insurer shall reinstate or renew the policy. The Commissioner may also order such other remedies and penalties as he or she deems appropriate and as are authorized by law in the event of an abusive nonrenewal or cancellation or in the event of a determination that the insurer has engaged in a pattern or practice of improper policy nonrenewal or cancellation procedures.

Rule 120-2-53-.06 Severability

If any provision of this Regulation, or the application thereof to any person or circumstance, is held invalid by a court of competent jurisdiction, the remainder of the Regulation or the applicability of such provision to other persons or circumstances shall not be affected.

Regulation of Rates

Summary of Georgia State Law 33-9-1 through 33-9-44

This chapter focuses on the **regulation of rates, underwriting rules, and related organizations** in the insurance industry. Here are the key points:

33-9-1 (Purpose and Construction): Establishes the purpose of the chapter, which is to ensure that insurance rates are not excessive, inadequate, or unfairly discriminatory[1].

33-9-2 (Definitions): Provides definitions for terms used throughout the chapter, such as “rate,” “rating organization,” and "underwriting rules"[1].

33-9-3 (Application of Chapter): Specifies the types of insurance and insurers to which the chapter applies[1].

33-9-4 (Standards for Rates): Sets standards for making and using rates, ensuring they are fair and reasonable[1].

33-9-5 to 33-9-11 (Joint Actions and Agreements): Authorizes joint actions by insurers, including agreements for the apportionment of high-risk applicants and cooperation among rating organizations[1].

33-9-12 to 33-9-15 (Licensing of Rating Organizations): Details the requirements for licensing rating organizations, including application procedures and fees[1].

33-9-16 to 33-9-19 (Conduct of Operations): Outlines the operational requirements for rating and advisory organizations, prohibiting unfair or unreasonable practices[1].

33-9-20 to 33-9-25 (Maintenance of Records and Examinations): Mandates the maintenance of records by organizations and insurers, and authorizes the Commissioner to conduct examinations[1].

33-9-26 to 33-9-36 (Filing and Approval of Rates): Requires insurers to file rates, rating plans, and underwriting rules with the Commissioner for approval[1].

33-9-37 to 33-9-44 (Miscellaneous Provisions): Includes various provisions related to the enforcement of the chapter, such as penalties for violations and the authority of the Commissioner to make rules and regulations[1].

References: 33 9-1 through 44

Summary: This chapter covers the standards and procedures for the regulation of insurance rates, underwriting rules, and related organizations in Georgia.

Section 33-9-1 - Purpose and construction of chapter

(a) The purpose of this chapter is to promote the public welfare by regulating insurance rates as provided in this chapter to the end that they shall not be excessive, inadequate, or unfairly discriminatory; to authorize the existence and operation of qualified rating organizations and advisory organizations and require that specified rating services of such rating organizations be generally available to all admitted insurers; and to authorize cooperation between insurers in rate making and other related matters.

(b) It is the express intent of this chapter to permit and encourage competition between insurers on a sound financial basis to the fullest extent possible.

However, nothing in this chapter is intended or should be construed to restrict the Commissioner in any way, on his own motion or otherwise, to take any affirmative action by rule, regulation, or administrative determination in a particular case, cases, or class of cases which he may deem necessary to protect the public's interest in maintaining the standards prescribed in Code Section 33-9-4; and Code Sections 33-9-26 through 33- 9-29 in particular shall in no way be viewed as exhaustive or restrictive of the powers or procedures available to the Commissioner for this purpose.

Section 33-9-2 - Definitions

As used in this chapter, the term:

"Advisory organization" means every person other than an admitted insurer, whether located within or outside this state, who prepares policy forms or makes underwriting rules incident to but

not including the making of rates, rating plans, or rating systems, or who collects and furnishes to admitted insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a rate-making, capacity. No duly authorized attorney at law acting in the usual course of his profession shall be deemed to be an advisory organization.

"Member" means an insurer who participates in or is entitled to participate in the management of a rating, advisory, or other organization.

"Rating organization" means every person other than an admitted insurer, whether located within or outside this state, who has as his object or purpose the making of rates, rating plans, or rating systems. Two or more admitted insurers who act in concert for the purpose of making rates, rating plans, or rating systems and who do not operate within the specific authorizations contained in Code Sections 33-9-6, 33-9-7, 33-9-11, 33-9-20, and 33-9-22 shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

"Subscriber" means an insurer which is furnished at its request with rates and rating manuals by a rating organization of which it is not a member, or with advisory services by an advisory organization of which it is not a member.

Section 33-9-3 - Application of chapter

This chapter shall apply to all insurance on risks or on operations in this state, except:

Reinsurance other than joint reinsurance to the extent stated in Code Section 33-9-19;

Life insurance; Disability income, specified disease, or hospital indemnity policies;

Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from transportation, insurance policies. Inland marine insurance shall be deemed to include insurance defined by statute, or by interpretation thereof or, if not so defined or interpreted, by ruling of the Commissioner or as established by general custom of the business, as inland marine insurance;

Insurance against loss of or damage to aircraft, insurance of hulls of aircraft, including their accessories and equipment, or insurance against liability arising out of the ownership, maintenance, or use of aircraft;

Title insurance; or

Annuities.

(a.1) The Commissioner may by rule or regulation establish criteria by which defined commercial risks may be exempted from the filing requirements of this chapter.

This chapter shall apply to all insurers, including stock and mutual companies, Lloyd's associations, and reciprocal and interinsurance exchanges, which under any laws of this state write any of the kinds of insurance to which this chapter applies.

Section 33-9-4 - Standards applicable to making and use of rates

The following standards shall apply to the making and use of rates pertaining to all classes of insurance to which this chapter is applicable:

Rates shall not be excessive or inadequate, as defined in this Code section, nor shall they be unfairly discriminatory;

No rate shall be held to be excessive unless such rate is unreasonably high for the insurance

provided and a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable; provided, however, with respect to rate filings involving an increase in rates, no rate for personal private passenger motor vehicle insurance shall be held to be excessive unless such rate is unreasonably high for the insurance provided and a reasonable degree of competition does not exist;

No rate shall be held inadequate unless it is unreasonably low for the insurance provided and continued use of it would endanger solvency of the insurer, or unless the use of such rate by the insurer using such rate has, or will, if continued, tend to destroy competition or create a monopoly;

Consideration shall be given to the extent applicable to past and prospective loss experience within and outside this state, to conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both country wide and those specially applicable to this state, to the insurer's average yield from investment income, and to all other factors, including judgment factors, deemed relevant within and outside this state; and, in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period;

Consideration may also be given, in the making and use of rates, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of any such insurer or group with respect to any kind of insurance or with respect to any subdivision or combination thereof;

Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses.

Classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations. Such classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions; provided, however, the Commissioner shall establish the maximum amount of any such modification;

Nothing contained in this Code section or elsewhere in this chapter shall be construed to repeal or modify Chapter 6 of this title, relating to unfair trade practices, and any rate, rating classification, rating plan or schedule, or variation thereof established in violation of Chapter 6 of this title shall, in addition to the consequences stated in Chapter 6 of this title or elsewhere, be deemed violative of this Code section;

No insurer shall base any standard or rating plan on vehicle insurance, in whole or in part, directly or indirectly, upon race, creed, or ethnic extraction; and

No insurer shall base any standard or rating plan on vehicle insurance, in whole or in part, directly or indirectly, upon any physical disability of an insured unless the disability directly impairs the ability of the insured to drive a motor vehicle.

Section 33-9-5 - Authorized joint actions by insurers generally

Subject to and in compliance with this chapter authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurance, two or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research.

Section 33-9-6 - Authorized joint actions by two or more admitted insurers having common ownership or operating under common management or control generally

With respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research, two or more admitted insurers having a common ownership or operating in this state under common management or control are authorized to act in concert between or among themselves the same as if they constituted a single insurer; and to the extent that the matters relate to cosurety bonds, two or more admitted insurers executing the bonds are authorized to act in concert between or among themselves the same as if they constituted a single insurer.

Section 33-9-7 - Authorized agreements among admitted insurers for apportionment of property and casualty insurance; approval by Commissioner; review of practices and activities

(a) Agreements may be made among admitted insurers with respect to the equitable apportionment among them of property and casualty insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods, and with respect to the use of reasonable rate modifications for such insurance, such agreements to be subject to the approval of the Commissioner.

(b) All such agreements shall be submitted in writing to the Commissioner for his consideration and approval together with such information as he may reasonably require. The Commissioner shall approve only such agreements as are found by him to contemplate the use of rates which meet the standards prescribed by this chapter and activities and practices that are not unfair, unreasonable, or otherwise inconsistent with this chapter.

(c) At any time after such agreements are in effect, the Commissioner may review the practices and activities of the adherents to such agreements and, if after a hearing upon not less than ten days' notice to such adherents he finds that any such practice or activity is unfair or unreasonable or is otherwise inconsistent with this chapter, he may issue a written order to the parties to any such agreement specifying in what respect such act or practice is unfair or unreasonable or otherwise inconsistent with this chapter and requiring the discontinuance of such activity or practice.

For good cause, and after hearing upon not less than ten days' notice to the adherents to such agreement, the Commissioner may revoke approval of any such agreement.

Section 33-9-8 - Agreements to share high-risk applicants; approval of rates

Agreements shall be made among admitted property and casualty insurers with respect to the equitable apportionment among them of property and casualty insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods upon the determination by the Commissioner in writing that an agreement relative to a given kind or kinds of property and casualty insurance is necessary to

protect the health, property, and welfare of the citizens of Georgia. All of the agreements shall be subject to the approval of the Commissioner and upon his or her approval shall have the effect of rules and regulations promulgated by the Commissioner.

All of the agreements shall be submitted in writing to the Commissioner for his or her consideration and approval within the period of time specified by the Commissioner in his or her determination, as provided for in this Code section, together with such information as he or she may reasonably require. The approval of the agreements shall comply with the requirements of the rule-making process as set forth in Code Section 33-2-9. The Commissioner shall approve only such agreements as are found by him or her to contemplate the use of rates which meet the standards prescribed by this chapter and activities and practices that are not unfair, unreasonable, or otherwise inconsistent with this chapter.

If, as provided in this Code section, the Commissioner determines that it is necessary to protect the health, property, and welfare of the citizens of this state, in addition to all other authority granted in this title, the Commissioner shall also have and may exercise the following authority:

The Commissioner may require that any rates contemplated to be used under this Code section shall be approved by him or her prior to their use;

The Commissioner may declare that any policies, contracts, or rates used pursuant to any agreement or plan established under this Code section shall be the exclusive policies, contracts, or rates authorized to be used in Georgia for the kind or kinds of insurance; and he or she may prohibit the use by any person of policies, contracts, or rates in this state which are different from those established in accordance with this Code section; and

The Commissioner may amend or modify in whole or in part and may adopt any agreement submitted to him or her in accordance with this Code section. If no agreement is submitted within the time prescribed by the Commissioner or if after a hearing the agreement submitted is unacceptable to the Commissioner, the Commissioner may on his or her own motion promulgate and adopt a reasonable plan to implement this Code section which plan shall become effective on a date not sooner than ten days as specified by the Commissioner in his or her order.

At any time after the agreements are in effect the Commissioner may review the practices and activities of the adherents to such agreements and, if after a hearing upon not less than ten days' notice to such adherents, he or she finds that any such practice or activity is unfair or unreasonable, or is otherwise inconsistent with this chapter, he or she may issue a written order to the parties of the agreement specifying in what respect the act or practice is unfair or unreasonable or otherwise inconsistent with this chapter and requiring the discontinuance of the activity or practice. For good cause, and after hearing upon not less than ten days' notice to the adherents thereto, the Commissioner may revoke approval of the agreement.

Whenever the Commissioner determines that a lack of competition or a lack of availability exists in this state in either property or casualty insurance, the Commissioner is authorized to protect the health, property, and welfare of the citizens of this state by exercising the following authority:

The Commissioner shall approve all rates contemplated to be used under this Code section prior to their use;

The Commissioner shall approve any policies or contracts used pursuant to any agreement or plan established under this Code section and such policies or contracts shall be used exclusively in this state for those kinds of insurance. The use by any person of any policies or contracts which are different from those established in accordance with this Code section shall

be prohibited; and

The Commissioner may by order implement a plan or program to provide the necessary insurance coverages to the citizens of this state by equitable apportionment among all property and casualty insurers licensed to transact those kinds of insurance in this state.

The powers contained in this Code section are cumulative and shall be in addition to all other powers of the Commissioner contained elsewhere in this title or under the laws of this state.

Section 33-9-9 - Use of rating systems, underwriting rules, or forms of rating or advisory organizations

Members and subscribers of rating or advisory organizations may use the rating systems, underwriting rules, or policy or bond form of the organizations and the rates filed by such organizations for all lines of insurance covered by the provisions of this chapter, either consistently or intermittently, but, except as provided in Code Sections 33-9-3, 33-9-7, 33-9- 19, and 33-9-20, shall not agree with each other or rating organizations or others to adhere to such rates, rating systems, underwriting rules, or policy or bond form. The fact that two or more admitted insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization, or the underwriting rules or policy or bond forms prepared by a rating or advisory organization shall not be sufficient in itself to support a finding that an agreement so to adhere exists and may be used only for the purpose of supplementing or explaining any competent evidence of the existence of the agreement.

Section 33-9-10 - Conduct of operations by organizations engaging in joint underwriting or reinsurance

Upon compliance with this chapter as applicable thereto, any rating organization, advisory organization, and any group, association, or other organization of admitted insurers which engages in joint underwriting or joint reinsurance through such organization or by standing agreement among the members thereof may conduct operations in this state. With respect to insurance risks or operations in this state, no insurer shall be a member or subscriber of any such organization, group, or association that has not complied with this chapter.

Section 33-9-11 - Authorization of cooperation among rating organizations and insurers; review of cooperative activities and practices by Commissioner and proceedings thereon

Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this chapter is authorized. The Commissioner may review the cooperative activities and practices and, if after a hearing he finds that the activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter, he may issue a written order specifying in what respects the activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter and requiring the discontinuance of the activity or practice.

Section 33-9-12 - Requirement of license for rating organization; application; fee

No rating organization shall conduct its operations in this state without first filing with the Commissioner a written application for and securing a license to act as a rating organization. Any rating organization may make application for and obtain a license as a rating organization if it shall meet the requirements for a license set forth in this chapter. Every rating organization shall file with its application:

A copy of its constitution; its articles of incorporation, agreement or association; and of its

bylaws, rules, and regulations governing the conduct of its business, all duly certified by the custodian of the originals of the constitution, articles of incorporation, agreement or association, bylaws, rules, and regulations;

A list of its members and subscribers;

The name and address of a resident of this state upon whom notices or orders of the Commissioner or process affecting the rating organization may be served; and

A statement of its qualifications as a rating organization.

The fee for filing an application for license as a rating organization shall be an amount as provided in Code Section 33-8-1, payable in advance to the Commissioner.

Section 33-9-13 - Evidence to be submitted by rating organization for license

To obtain and retain a license, a rating organization shall provide satisfactory evidence to the Commissioner that it will:

Permit any admitted insurer to become a member of or a subscriber to such rating organization at a reasonable cost and without discrimination, or withdraw therefrom;

Neither have nor adopt any rule or exact any agreement the effect of which would be to require any member or subscriber, as a condition to membership or subscribership, to adhere to its rates, rating plans, rating systems, underwriting rules, or policy or bond forms;

Neither adopt any rule nor exact any agreement the effect of which would be to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

Neither practice nor sanction any plan or act of boycott, coercion, or intimidation;

Neither enter into nor sanction any contract or act by which any person is restrained from lawfully engaging in the insurance business;

Notify the Commissioner promptly of every change in its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules, and regulations governing the conduct of its business; its list of members and subscribers; and the name and address of the resident of this state designated by it upon whom notices or orders of the Commissioner or process affecting such organization may be served; and

Comply with Code Section 33-9-20.

Section 33-9-14 - Examination of rating organization application; investigation of applicant; issuance of license; duration of license

The Commissioner shall examine each application for license to act as a rating organization and the documents filed therewith and may make such further investigation of the applicant, its affairs, and its proposed plan of business as he deems desirable.

The Commissioner shall issue the license applied for within 60 days of its filing with him, if from such examination and investigation he is satisfied that:

The business reputation of the applicant and its officers is good;

The facilities of the applicant are adequate to enable it to furnish the services it proposes to furnish; and

The applicant and its proposed plan of operation conform to the requirements of this chapter.

Otherwise, but only after hearing upon notice, the Commissioner shall in writing deny the application and notify the applicant of his decision and his reasons therefor.

The Commissioner may grant an application in part only and issue a license to act as a rating organization for one or more of the classes of insurance or subdivisions thereof or class of risk or a part or combination thereof as are specified in the application if the applicant qualifies for only a portion of the classes applied for.

Licenses issued pursuant to this Code section shall remain in effect until revoked as provided in this chapter.

Section 33-9-15 - Annual license fee for rating organizations

Notwithstanding Code Section 33-9-14, each rating organization possessing a license of indefinite term pursuant to such Code section shall owe and pay to the Commissioner an annual fee as provided in Code Section 33-8-1 in advance on account of such license until its final termination. Such fee shall be for periods commencing on July 1 of each year and ending on June 30 and shall be due and payable on March 1 of each year and shall be delinquent on April 1 of each year.

Section 33-9-16 - Adoption by rating organizations of rules governing eligibility for membership generally

Subject to the approval of the Commissioner, licensed rating organizations may make reasonable rules governing eligibility for membership.

Section 33-9-17 - Requirement by rating organizations of membership by all insurers having common ownership or operating under common management

If two or more insurers having a common ownership or operating in this state under common management are admitted for the classes or types of insurance for which a rating organization is licensed to make rates, the rating organization may require as a condition to membership or subscribership of one or more that all the insurers shall become members or subscribers.

Section 33-9-18 - Requirements for conduct of operations by advisory organizations generally; engaging in unfair or unreasonable practices

No advisory organization shall conduct its operations in this state unless and until it has filed with the Commissioner a copy of its constitution, articles of incorporation, agreement, or association, and of its bylaws or rules and regulations governing its activities, all duly certified by the custodian of the originals of the constitution, articles of incorporation, agreement or association, and bylaws or rules and regulations; a list of its members and subscribers; and the name and address of a resident of this state upon whom notices or orders of the Commissioner or process may be served.

Each advisory organization shall notify the Commissioner promptly of every change in its constitution, its articles of incorporation, agreement, or association, and of its bylaws or rules and regulations governing the conduct of its business; its list of members and subscribers; and the name and address of the resident of this state designated by it upon whom notices or orders of the Commissioner or process affecting the organization may be served.

No advisory organization shall engage in any unfair or unreasonable practice with respect to its activities.

Each advisory organization shall pay an annual fee as provided in Code Section 33-8-1.

Section 33-9-19 - Requirements for conduct of operations by organizations engaging in joint underwriting and joint reinsurance generally; engaging in unfair or unreasonable practices

Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance through the group, association, or organization or by standing agreement among the members of the group, association, or organization shall file with the Commissioner a copy of its constitution, its articles of incorporation, agreement, or association, and of its bylaws or rules and regulations governing its activities, all duly certified by the custodian of the originals of such constitution, articles of incorporation, agreement or association, bylaws or rules and regulations; a list of its members; and the name and address of a resident of this state upon whom notices or orders of the Commissioner or process may be served.

Each group, association, or other organization shall notify the Commissioner promptly of every change in its constitution, its articles of incorporation, agreement, or association, and its bylaws, rules, and regulations governing the conduct of its business; its list of members; and the name and address of the resident of this state designated by it upon whom notices or orders of the Commissioner or process affecting the group, association, or organization may be served.

No group, association, or organization shall engage in any unfair or unreasonable practice with respect to its activities.

Each joint underwriting and joint reinsurance organization shall pay an annual fee as provided in Code Section 33-8-1.

Section 33-9-20 - Maintenance of records by organizations generally; maintenance and reporting of statistics by insurers

Every insurer, rating organization, or advisory organization and every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance shall maintain reasonable records of the type and kind reasonably adapted to its method of operation, of its experience or the experience of its members, and of the data, statistics, or information collected or used by it in connection with the rates, rating plans, rating systems, underwriting rules, policy or bond forms, surveys, or inspections made or used by it so that the records will be available at all reasonable times to enable the Commissioner to determine whether the organization, insurer, group, or association and, in the case of an insurer or rating organization, every rate, rating plan, and rating system made or used by it complies with this chapter as applicable to it. The maintenance of the records in the office of a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this Code section for any insurer maintaining membership or subscribership in the organization to the extent that the insurer uses the rates, rating plans, rating systems, or underwriting rules of the organization. Such records shall be maintained in an office within this state and shall be made available for examination or inspection by the Commissioner at any time.

Each insurer shall maintain statistics under statistical plans compatible with the rating plans used. An insurer shall report its statistics through a recognized statistical agency or advisory organization.

No insurer shall be required to report its statistics through such agencies or organizations with respect to any unique or unusual risks or with respect to any risks rated in accordance with Code Section 33-9-32 or any lines or sublines of insurance for which such agencies or organizations do not promulgate rates or rating systems. Moreover, the Commissioner shall withhold from public inspection any proprietary information of any insurer, agency, or organization.

Section 33-9-21 - Maintenance and filing rates, rating plans, rating systems, or underwriting

rules; examination of claim reserve practices by Commissioner

Every insurer shall maintain with the Commissioner copies of the rates, rating plans, rating systems, underwriting rules, and policy or bond forms used by it. The maintenance of rates, rating plans, rating systems, underwriting rules, and policy or bond forms with the Commissioner by a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this Code section for any insurer maintaining membership or subscriberships in such organization, to the extent that the insurer uses the rates, rating plans, rating systems, underwriting rules, and policy or bond forms of such organization; provided, however, that the Commissioner, when he or she deems it necessary, without compliance with the rule-making procedures of this title or Chapter 13 of Title 50, the "Georgia Administrative Procedure Act":

May require any domestic, foreign, and alien insurer to file the required rates, rating plans, rating systems, underwriting rules, and policy or bond forms used independent of any filing made on its behalf or as a member of a licensed rating organization, as the Commissioner shall deem to be necessary to ensure compliance with the standards of this chapter and Code Section 34-9-130 and for the best interests of the citizens of this state;

Shall require each domestic, foreign, and alien insurer, writing or authorized to write workers' compensation insurance in this state, to file such insurer's own individual rate filing for rates to be charged for workers' compensation insurance coverage written in this state. Such rates shall be developed and established based upon each individual insurer's experience in the State of Georgia to the extent actuarially credible.

The experience filed shall include the loss ratios, reserves, reserve development information, expenses, including commissions paid and dividends paid, investment income, pure premium data adjusted for loss development and loss trending, profits, and all other data and information used by that insurer in formulating its workers' compensation rates which are used in this state and any other information or data required by the Commissioner. In establishing and maintaining loss reserves, no workers' compensation insurer shall be allowed to maintain any excess loss reserve for any claim or potential claim for more than 90 days after the amount of liability for such claim or potential claim has been established, whether by final judgment, by settlement agreement, or otherwise. This limitation on the maintenance of loss reserves shall be enforced through this Code section, as well as through Code Section 33-9-23, relating to examination of admitted insurers, and any other appropriate enforcement procedures. The Commissioner is authorized to accept such rate classifications as are reasonable and necessary for compliance with this chapter. A rate filing required by this paragraph shall be updated by the insurer at least once every two years; and

As used in paragraph (2) of this subsection, the term "excess loss reserve" means any reserve amount in excess of the reserve required by law.

Any domestic, foreign, or alien insurer that is authorized to write insurance in this state must file with the Commissioner any rate, rating plan, rating system, or underwriting rule for all personal private passenger motor vehicle insurance:

For private passenger motor vehicle insurance providing only the mandatory minimum limits required by Code Section 33-34-4 and subsection

of Code Section 40-9-37, no such rate, rating plan, rating system, or underwriting rule shall become effective, nor may any premium be collected by any insurer thereunder, unless the filing has been received by the Commissioner in his or her office and such filing has been approved by the Commissioner or a period of 45 days has elapsed from the date such filing was received by

the Commissioner during which time such filing has not been disapproved by the Commissioner. The Commissioner shall be authorized to extend such 45 day period by no more than 55 days at his or her discretion. If a filing is disapproved, notice of such disapproval order shall be given within 100 days of receipt of filing by the Commissioner, specifying in what respects such filing fails to meet the requirements of this chapter.

The filer shall be given a hearing upon written request made within 30 days after the issuance of the disapproval order, and such hearing shall commence within 30 days after such request unless postponed by mutual consent. Such hearing, once commenced, may be postponed or recessed by the Commissioner only for weekends, holidays, or after normal working hours or at any time by mutual consent of all parties to the hearing. The Commissioner may also, at his or her discretion, recess any hearing for not more than two recess periods of up to 15 consecutive days each. In connection with any hearing or judicial review with respect to the approval or disapproval of such rates, the burden of persuasion shall fall upon the affected insurer or insurers to establish that the challenged rates are adequate, not excessive, and not unfairly discriminatory. After such a hearing, the Commissioner must affirm, modify, or reverse his or her previous action within the time period provided in subsection (a) of Code Section 33-2-23 relative to orders of the Commissioner. The requirement of approval or disapproval of a rate filing by the Commissioner under this subsection shall not prohibit actions by the Commissioner regarding compliance of such rate filing with the requirements of Code Section 33-9-4 brought after such approval or disapproval.

For personal private passenger motor vehicle insurance other than that described in paragraph (1) of this subsection, such rate, rating plan, rating system, or underwriting rule for all such personal private passenger motor vehicle insurance shall be effective 60 days after such filing and shall be implemented without approval of the Commissioner, unless an earlier effective date is authorized by the Commissioner or a later effective date is specified by the insurer. This paragraph shall apply to the entire personal private passenger motor vehicle insurance policy with limits above the mandatory minimum required by Code Section 33-34-4 and subsection (a) of Code Section 40-9-37 and shall apply to the entire personal private passenger motor vehicle policy with minimum limits if such policy has any additional nonmandatory coverage or coverages.

Notwithstanding the provisions of paragraphs (1) and (2) of this subsection, an insurer may, but shall not be required to, file its rate, rating plan, rating system, or underwriting rule for all such personal private passenger motor vehicle insurance provided for in paragraphs (1) and (2) of this subsection under the filing process of paragraph (1) of this subsection.

When a rate filing of an insurer required under paragraph (1) of subsection (b) of this Code section is not accompanied by the information upon which the insurer supports the filing and the Commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, then the Commissioner shall request in writing, within 20 days of the date he or she receives the filing, the specifics of such additional information as he or she requires, and the insurer shall be required to furnish such information, and in such event the 45 day period provided for in paragraph (1) of subsection (b) of this Code section shall commence as of the date such information is furnished.

Any domestic, foreign, or alien insurer that is authorized to write insurance in this state must file with the Commissioner any rate, rating plan, rating system, or underwriting rule at least 45 days prior to any indicated effective date for all insurance other than personal private passenger motor vehicle insurance. No rate, rating plan, rating system, or underwriting rule required to be filed under this subsection will become effective, nor may any premium be collected by any insurer

thereunder, unless the filing has been received by the Commissioner in his office not less than 45 days prior to its effective date.

When a rate filing of an insurer required under subsection (d) of this Code section results in any overall rate increase of 10 percent or more within any 12 month period, the Commissioner shall order an examination of that insurer to determine the accuracy of the claim reserves, the applicability of the claim reserve practices for the loss data used in support of such filing, and any other component of the rate filing; provided, however, that in the event the overall increase is less than 25 percent within any 12 month period and the Commissioner affirmatively determines that he or she has sufficient information to evaluate such rate increase and that the cost thereof would not be justified, he or she may waive all or part of such examination. In all other rate filings required under subsection (d) of this Code section, the Commissioner may order an examination of that insurer as provided in this subsection. Such examination shall be conducted in accordance with the provisions of Chapter 2 of this title. Upon notification by the Commissioner of his or her intent to conduct such examination, the insurer shall be prohibited from placing the rates so filed in effect until such examination has been reviewed and certified by the Commissioner as being complete.

Such examination, if conducted by the Commissioner, shall be reviewed and certified within 90 days of the date such rate, rating plan, rating system, or underwriting rule is filed; provided, however, that if the Commissioner makes an affirmative finding that the examination may not be completed within the 90 day period, he or she may extend such time for one additional 60 day period. Any examination required under this Code section shall be conducted in accordance with Chapter 2 of this title.

Notwithstanding the provisions of subsection (d) of this Code section, in the event the filing of any rate, rating plan, rating system, or underwriting rule under subsection (d) of this Code section is not necessary, in the judgment of the Commissioner, to accomplish the purposes of this chapter as set forth in Code Section 33-9-1, then the Commissioner may exempt all domestic, foreign, and alien insurers from being required to file such rate, rating plan, rating system, or underwriting rule.

Filings required pursuant to this Code section shall be accompanied by a fee or fees as provided in Code Section 33-8-1.

Section 33-9-21.1 - Filing and maintenance of information relating to certain casualty insurance

The following types of casualty insurance shall be filed separately and data relative to such types of insurance shall be maintained separately:

Nonrecording insurance or nonfiling insurance; and

Vendors' single interest insurance.

Section 33-9-21.2 - Petition for hearing by aggrieved insurer

Any insurer aggrieved by the Commissioner's disapproval of any rate filing may petition the Commissioner for a hearing within ten days of the notification of such disapproval, unless otherwise specifically provided by law. A hearing conducted pursuant to this Code section shall be conducted in accordance with the provisions of Chapter 2 of this title.

Section 33-9-22 - Conduct of examinations of organizations by Commissioner generally; acceptance of reports of insurance supervisory officials of other states

The Commissioner shall, at least once every five years, and may, as often as may be reasonable and necessary, make or cause to be made an examination of each licensed rating organization; and he may, as often as may be reasonable and necessary, make or cause to be made an examination of any advisory organization or group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance.

In lieu of the examination required in subsection (a) of this Code section, the Commissioner may accept the report of an examination made by the insurance supervisory official of another state.

In examining any organization, group, or association pursuant to this Code section, the Commissioner shall ascertain whether the organization, group, or association and, in the case of a rating organization, any rate or rating system made or used by it complies with the applicable requirements and standards of this chapter.

Section 33-9-23 - Examination of admitted insurers; examination of insurers transacting workers' compensation insurance

The Commissioner may, at any reasonable time, make or cause to be made an examination of every admitted insurer transacting any class of insurance to which this chapter is applicable to ascertain whether the insurer and every rate and rating system used by it for each class of insurance complies with the requirements and standards of this chapter applicable thereto. The examination shall not be a part of a periodic general examination participated in by representatives of more than one state.

In addition to and apart from the examination required by subsection (a) of this Code section, the Commissioner may, at any reasonable time, examine or cause to be examined by some examiner duly authorized by him or her all insurers transacting workers' compensation insurance in this state. This examination will include a review of the loss ratios, reserves, reserve development information, expenses including commissions paid and dividends paid, investment income, pure premium data adjusted for loss development and loss trending, profits, and all other data and information used by that insurer in formulating its workers' compensation rates which are used in this state and any other information or data required by the Commissioner.

Upon completion of this examination, a report in such form as the Commissioner shall prescribe shall be filed in his or her office.

Section 33-9-24 - Examination of officers, managers, agents, and employees of organizations and insurers

The officers, managers, agents, and employees of any such organization, group, association, or insurer may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation, together with all data, statistics, and information of every kind and character collected or considered by such organization, group, association, or insurer in the conduct of the operations to which the examination relates.

Section 33-9-25 - Payment of costs of examinations

The reasonable cost of any examination authorized by this chapter shall be paid by the organization, group, association, or insurer to be examined.

Section 33-9-26 - Review of rate, rating plan, rating system, or underwriting rule by insurer or rating organization

Any person aggrieved by any rate charged, rating plan, rating system, or underwriting rule followed or adopted by an insurer or rating organization may request the insurer or rating organization to review the manner in which the rate, plan, system, or rule has been applied with respect to insurance afforded him. The request may be made by his authorized representative and shall be written. If the request is not granted within 30 days after it is made, the requestor may treat it as rejected. Any person aggrieved by the action of an insurer or rating organization in refusing the review requested or in failing or refusing to grant all or part of the relief requested may file a written complaint and request for hearing with the Commissioner, specifying the

grounds relied upon. If the Commissioner has information concerning a similar complaint, he may deny the hearing. If he believes that probable cause for the complaint does not exist or that the complaint is not made in good faith, he shall deny the hearing. Otherwise, and if he finds that the complaint charges a violation of this chapter and that the complainant would be aggrieved if the violation is proven, he shall proceed as provided in Code Section 33-9-27.

Section 33-9-27 - Issuance of notice by Commissioner upon determination of noncompliance with requirements of chapter

If after examination of an insurer, rating organization, advisory organization, or group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance, or upon the basis of other information, or upon sufficient complaint as provided in Code Section 33-9-26 the Commissioner has good cause to believe that the insurer, organization, group, or association, or any rate, rating plan, or rating system made or used by any insurer or rating organization does not comply with the requirements and standards of this chapter applicable to it, he shall, unless he has good cause to believe such noncompliance is willful, give notice in writing to such insurer, organization, group, or association stating in the notice to the extent practicable in what manner such noncompliance is alleged to exist and specifying in the notice a reasonable time, not less than ten days after notice, in which the noncompliance may be corrected.

Section 33-9-28 - Conduct of hearing by Commissioner upon failure to correct noncompliance; notice of hearing; matters considered at hearing

If the Commissioner has good cause to believe the noncompliance to be willful, or if within the period prescribed by the Commissioner in the notice required by Code Section 33-9-27 the insurer, organization, group, or association does not make the changes necessary to correct the noncompliance specified by the Commissioner or establish to the satisfaction of the Commissioner that the specified noncompliance does not exist, then the Commissioner may hold a public hearing in connection with the noncompliance, provided that within a reasonable period of time, which shall be not less than ten days before the date of the hearing, he shall mail written notice specifying the matters to be considered at the hearing to the insurer, organization, group, or association. If no notice has been given as provided in Code Section 33-9-27, the notice provided for in this Code section shall state to the extent practicable in what manner such noncompliance is alleged to exist. The hearing shall not include any additional subjects not specified in the notices required by Code Section 33- 9-27 or this Code section.

Section 33-9-28.1 - Assessment of investigation costs against parties

The costs incurred by the Commissioner in conducting any hearing under this chapter may be assessed against the parties to the hearing in such proportion as the Commissioner may determine upon consideration of all relevant circumstances including, but not limited to, the nature of the hearing; whether the hearing was instigated by or for the benefit of a particular party or parties; whether there is a successful party on the merits of the proceeding; and the relative levels of participation by the parties. For purposes of this Code section, costs incurred shall include payments made by the Commissioner to obtain the services of independent contractors or outside experts and travel expenses of such contractors or experts. The Commissioner shall make the assessment of costs incurred as part of the final order or decision arising out of the proceeding; provided, however, that any order or decision shall include findings and conclusions of the Commissioner or his designee to support the assessment of costs.

Section 33-9-29 - Issuance of remedial orders by Commissioner generally; suspension or revocation of certificate of authority or license

If after a hearing pursuant to Code Section 33-9-28 the Commissioner finds:

That any rate, rating plan, or rating system violates the applicable provisions of this chapter, he may issue an order to the insurer or rating organization which has been the subject of the hearing specifying in what respects the violation exists and stating when, within a reasonable period of time, the further use of the rate or rating system by the insurer or rating organization in contracts of insurance made thereafter shall be prohibited and may further order that the portion of premiums received from current policyholders as a result of the most recent rate increase at the time the notice of such hearing is issued shall be refunded to the policyholders;

That an insurer, rating organization, advisory organization, or a group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance is in violation of the provisions of this chapter applicable to it other than the provisions dealing with rates, rating plans, or rating system, he may issue an order to the insurer, organization, group, or association which has been the subject of the hearing specifying in what respects the violation exists and requiring compliance within a reasonable time thereafter;

That the violation of this chapter applicable to it by any insurer or rating organization which has been the subject of the hearing was willful, he may suspend or revoke, in whole or in part, the certificate of authority of each insurer or the license of each rating organization with respect to the class of insurance which has been the subject matter of the hearing;

That any rating organization has willfully engaged in any fraudulent or dishonest act or practices, he may suspend or revoke, in whole or in part, the license of the organization in addition to any other penalty provided in this chapter.

Section 33-9-30 - Suspension or revocation of license or certificate of authority for failure to comply with order of Commissioner

In addition to other penalties provided in this title, the Commissioner, by order pursuant to Code Section 33-9-29, may suspend or revoke, in whole or in part, the license of any rating organization or the certificate of authority of any insurer with respect to the class or classes of insurance specified in such order if such entity fails to comply within the time limited by such order or any extension thereof that the Commissioner may grant.

Section 33-9-31 - Manner of conduct of proceedings in connection with denial, suspension, or revocation of license or certificate of authority

Except as otherwise provided in this chapter, all proceedings in connection with the denial, suspension, or revocation of a license or certificate of authority under this chapter shall be conducted in accordance with Chapter 2 of this title; and the Commissioner shall have all the powers granted to him in Chapter 2 of this title.

Section 33-9-32 - Validity of contracts to use rates in excess of, or lower than, generally applicable rates

Nothing contained in this chapter shall be deemed to prohibit an insurer and its insured from contracting to use a rate on a specific risk or risks which is in excess of or lower than that otherwise applicable, provided that the contract and rate deviation by consenting parties have been filed with the Commissioner prior to the use of the rate in accordance with the procedures, conditions, and limitations as may be established by the Commissioner; and provided, further, that, if the resulting premium exceeds $1,000.00, a binder of coverage may be issued and the contract and rate deviation shall be filed within 20 days after the issuance of the binder.

Such contract and rate deviation shall be subject to challenge by the Commissioner for a period

of ten days after filing. If such challenge is upheld, the insurer shall be required to use its regular filed rates for the first 30 days of coverage in accordance with the requirements of applicable law. If there is no challenge or if a challenge is not upheld, the contract and rate deviation agreed upon may be used from and after the effective date of the binder.

Section 33-9-33 - Payment of dividends, savings, or unabsorbed premium deposits by insurers

Nothing in this chapter shall be construed to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers shall not be deemed a rating plan or system.

Section 33-9-34 - Acts done, actions taken, or agreements made pursuant to

No act done, action taken, or agreement made pursuant to the authority conferred by this chapter shall constitute a violation of or grounds for prosecution or civil proceedings under any other law of this state which does not specifically refer to insurance.

Section 33-9-35 - Withholding of information; false or misleading information

No person, insurer, or organization shall willfully withhold information from, or knowingly give false or misleading information to, the Commissioner or to any rating organization, advisory organization, insurer, or group, association, or other organization of insurers which will affect the rates, rating systems, or premiums for the classes of insurance to which this chapter is applicable.

Section 33-9-36 - Unauthorized premiums; unlawful inducements

As used in this Code section, the term:

"Gift certificate" shall have the same meaning as provided in Code Section 10-1-393.

"Insurance" includes suretyship.

"Policy" includes bond.

"Store gift card" shall have the same meaning as provided in Code Section 10-1-393.

No broker or agent shall knowingly charge, demand, or receive a premium for any policy of insurance except in accordance with this chapter.

No insurer or employee of such insurer and no broker or agent shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly as an inducement to insurance or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue on such policy of insurance, or any valuable consideration or inducement whatever, not specified in the policy of insurance, except to the extent provided for in an applicable filing. No insured named in a policy of insurance nor any employee of the insured shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit, or reduction of premium, or any special favor or advantage or valuable consideration or inducement.

Nothing in this Code section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed agents and brokers, nor as prohibiting any insurer from allowing or returning to its participating policyholders, members, or subscribers dividends, savings, or unabsorbed premium deposits.

Nothing in this Code section shall be construed as prohibiting the payment for food or refreshments by an insurer or employee of such insurer or a broker or an agent for current or prospective clients during sales presentations and seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars.

Nothing in this Code section shall be construed as prohibiting an insurer or employee of such insurer or a broker or an agent from advertising or conducting promotional programs by insurers or insurance producers whereby prizes, goods, wares, store gift cards, gift certificates, sporting event tickets, or merchandise, not exceeding $100.00 in value per customer in the aggregate in any one calendar year, are given to current or prospective customers; provided, however, that the giving of any item or items of value under this subsection shall not be contingent on the sale or renewal of a policy.

Section 33-9-37 - Liability of insurer conspiring to fix insurance rates unauthorized by chapter

In the event any insurer shall in collusion with any other insurer conspire to fix, set, or adhere to insurance rates, except as expressly sanctioned by this chapter, the insurer shall be liable to any person damaged thereby for an amount equal to three times the amount of the damage together with the damaged party's attorney's fees.

Section 33-9-38 - Penalty for failure to comply with final order of Commissioner; penalty for willful violation of provision of chapter

Any person, insurer, organization, group, or association who fails to comply with a final order of the Commissioner under this chapter shall be liable to the state in an amount not exceeding $50.00; but, if such failure is willful, the person, insurer, organization, group, or association shall be liable to the state in an amount not exceeding $5,000.00. The Commissioner shall collect the amount so payable and may bring an action in the name of the people of the State of Georgia to enforce collection. Such penalties may be in addition to any other penalties provided by law.

Any person who willfully violates this chapter shall be guilty of a misdemeanor.

Section 33-9-39 - Restrictions on motor vehicle insurance surcharges relating to accidents involving law enforcement officers, firefighters, or emergency medical technicians

No insurer shall surcharge the premium or rate charged on a policy of motor vehicle insurance that provides coverage for the personal motor vehicles of any law enforcement officer, firefighter, or emergency medical technician in this state for any accident:

That occurred while the law enforcement officer, firefighter, or emergency medical technician was lawfully engaged in the performance of official duties; and

For which the law enforcement officer, firefighter, or emergency medical technician furnishes proof, in the form of copies of the accident report, 9-1-1 emergency dispatch log, or the employing agency's documents, to the insurer of the condition provided in paragraph (1) of this Code section.

Section 33-9-40 - Prohibition of motor vehicle insurance surcharges relating to accidents in which insured not at fault

No insurer shall surcharge the premium or rate charged on a policy of motor vehicle insurance or cancel such policy as a result of the insured person's involvement in a multivehicle accident when such person was not at fault in such accident.

Section 33-9-40.1 - Rates of workers' compensation policies issued to business entities with majority interest held by the same person; limitation on maintenance of reserves; investigations of complaints

An insurer shall not assign an adverse experience modification factor which is applicable to the rate of a workers' compensation insurance policy issued to a particular business entity to the rate of a workers' compensation policy issued to another business entity maintaining a separate payroll for federal and state tax purposes and engaging in a distinctly different business enterprise for the sole reason that the majority interest in both business entities is held by the same person.

For experience rating purposes, no workers' compensation insurer shall maintain any case reserve for any claim in excess of the amount established by final judgment, by settlement, or otherwise. All reductions in case reserves shall be made and reported to the appropriate rating organization within 90 days. Any further adjustments upward in the case reserve shall only be made due to additional paid claims or a case reserve established on a claim which was previously closed but reopened due to a claimant's request for additional benefits. This limitation on the maintenance of reserves shall be enforced through this Code section, as well as through Code Section 33-9-21, relating to rate filings, Code Section 33-9-23, relating to examination of insurers, and any other appropriate enforcement procedures.

The Commissioner shall cause an investigation to be made of each complaint filed by a licensee under this title or under Article 5 of Chapter 9 of Title 34 or a person acting for or on behalf of such licensee against an insurer or workers' compensation group self-insurance fund alleging that such insurer or fund is:

Using an improper rate;

Using an improper classification; or

Using an improper experience modification in issuing a contract of workers' compensation insurance.

If the Commissioner finds the complaint to be justified, in addition to all other appropriate action under this title, the Commissioner may assess the cost of such investigation against the insurer or workers' compensation group self-insurance fund and retain the proceeds therefrom for reimbursement of the cost of conducting such investigation.

If the person making the complaint is a licensee under this title or under Article 5 of Chapter 9 of Title 34 or a person acting for or on behalf of such licensee and the Commissioner finds the complaint not to be justified, the Commissioner may, in addition to all other appropriate action under this title:

Assess the reasonable verified cost of such investigation against such person and retain the proceeds therefrom for reimbursement of the cost of conducting such investigation; and

If such person files six or more complaints the Commissioner finds not to be justified in any 12 month period, assess an administrative penalty not to exceed $2,000.00 for the sixth and each subsequent complaint found to be not justified.

Section 33-9-40.2 - Workers' compensation insurance premium discount for insured with drug-free workplace program

For each policy of workers' compensation insurance issued or renewed in the state on and after July 1, 1993, there shall be granted by the insurer not less than a 7 1/2 percent reduction in the

premium for such policy if the insured has been certified by the State Board of Workers' Compensation as having a drug-free workplace program which complies with the requirements of Article 11 of Chapter 9 of Title 34 and has notified its insurer in writing of such certification.

The premium discount provided by this Code section shall be applied to an insured's policy of workers' compensation insurance pro rata as of the date the insured receives certification by the State Board of Workers' Compensation and shall continue for as long as the insured maintains the certification as having a drug-free workplace; provided, however, that an insurer shall not be required to credit the actual amount of the premium discount to the account of the insured until the final premium audit under such policy. Certification by an insured shall be required for each year in which such premium discount is granted.

The workers' compensation insurance policy of an insured shall be subject to an additional premium for the purposes of reimbursement of a previously granted premium discount and to cancellation in accordance with the provisions of the policy if it is determined by the State Board of Workers' Compensation that such insured misrepresented the compliance of its drug- free workplace program with the provisions of Article 11 of Chapter 9 of Title 34.

Each insurer shall make an annual report to the rating and statistical organization designated by the Commissioner pursuant to this chapter illustrating the total dollar amount of drug-free workplace premium credit. Standard earned premium figures reported pursuant to this subsection on the aggregate calls for experience must reflect the effects of such credits. The net standard premium will then be the basis of any premium adjustment. The drug-free workplace credits must be reported under a unique classification code or unit statistical reports submitted to the rating and statistical organization designated by the Commissioner pursuant to this chapter.

The Commissioner shall conduct a study to determine the impact of this chapter on reducing workers' compensation losses and on the impact of the premium credit provided pursuant to this Code section in encouraging employers to implement and maintain the program for which the credit is provided.

The Commissioner shall be authorized to promulgate rules and regulations necessary for the implementation and enforcement of this Code section.

Section 33-9-40.3 - Employers to provide work based learning opportunities for students age 16 and older

For each policy of workers' compensation insurance issued or renewed in the state on and after July 1, 2016, there may be granted by the insurer up to a 5 percent reduction in the premium for such policy if the insured has been certified by the State Board of Education to the State Board of Workers' Compensation as a work based learning employer pursuant to Article 12 of Chapter 9 of Title 34 and has notified its insurer in writing of such certification.

If granted, the premium discount provided by this Code section shall be applied to an insured's policy of workers' compensation insurance pro rata as of the date the insured receives such certification and shall continue for as long as the insured maintains the certification; provided, however, that an insurer shall not be required to credit the actual amount of the premium discount to the account of the insured until the final premium audit under such policy. Certification of an insured shall be required for each year in which a premium discount is granted.

If it is determined that an insured misrepresented its qualifications for certification pursuant to Article 12 of Chapter 9 of Title 34, the workers' compensation insurance policy of such insured

may be subject to an additional premium for the purposes of reimbursement of a previously granted premium discount and to cancellation in accordance with the provisions of the policy.

Each insurer shall make an annual report, in accordance with guidelines established by the Commissioner, to the rating and statistical organization designated by the Commissioner illustrating the total dollar amount of the premium discounts applied pursuant to this Code section.

The Commissioner shall conduct a study to determine the impact of the premium discounts provided pursuant to this Code section in encouraging employers to provide work based learning opportunities for students age 16 or older.

The Commissioner shall be authorized to promulgate rules and regulations necessary for the implementation and enforcement of this Code section.

Section 33-9-41 - [Repealed] Study of effect of 1987 legislation on loss experience; cooperation of insurers; report to General Assembly

Repealed and reserved by 2001 Ga. Laws 2, § 33, eff. 2/12/2001.

Section 33-9-42 - Reduction in premiums for motor vehicle liability, first-party medical, and collision coverages for certain named drivers

(a) For each personal or family-type policy of private passenger motor vehicle insurance issued or issued for delivery in this state, there shall be offered by the insurer a reduction of not less than 10 percent in premiums for motor vehicle liability, first-party medical, and collision coverages to the policyholder if all named drivers, as listed or who should be listed on the policy application or provided in information subsequent to such application, of each motor vehicle covered by such policy satisfy the requirements of subsection (b) or subsection (c), as applicable, of this Code section.

Reductions in premiums shall be available if all named drivers who are 25 years of age or older:

Have committed no traffic offenses for the prior three years or since the date of licensure, whichever is shorter;

Have had no claims based on fault against an insurer for the prior three years; and

Complete one of the following types of driving courses:

A defensive driving course of not less than six hours from a driver improvement clinic or commercial or noncommercial driving school approved by and under the jurisdiction of the Department of Driver Services;

An emergency vehicles operations course at the Georgia Public Safety Training Center;

A defensive driving course of not less than six hours from a driver improvement program which is administered by a nonprofit organization such as the AARP, the American Automobile Association, the National Safety Council, or a comparable organization and which meets the rules and regulations of the Department of Driver Services pursuant to subsection (g) of this Code section; or

A defensive driving course of not less than six hours which is offered by an employer to its employees and their immediate families and which meets the rules and regulations of the Department of Driver Services.

Reductions in premiums shall be available if all named drivers who are under 25 years of age:

Have committed no traffic offenses for the prior three years or since the date of licensure, whichever is shorter;

Have had no claims based on fault against an insurer for the prior three years; and

Complete a preparatory course offered to new drivers of not less than 30 hours of classroom training and not less than six hours of practical training by a driver's training school approved by and under the jurisdiction of the Department of Driver Services or by an accredited secondary school, junior college, or college.

Upon completion of one of the defensive driving courses specified in paragraph (3) of subsection (b) or preparatory courses offered to new drivers specified in paragraph (3) of subsection (c), as applicable, of this Code section by each named driver, eligibility for reductions in premiums for such policy shall continue for a period of three years, provided any named driver under such policy does not commit a traffic offense or have a claim against the policy based on any such driver's fault.

The Department of Driver Services shall assure through the supervision of driver improvement clinics, emergency vehicles operations courses, driver improvement programs administered by nonprofit organizations, and commercial or noncommercial driving schools approved by the Department of Driver Services that defensive driving courses shall be available and accessible wherever practicable as determined by the department to licensed drivers throughout the state.

Each insurer providing premium discounts under this Code section shall provide, upon the request of the Commissioner, information regarding the amount of such discounts in a form acceptable to the Commissioner.

The power of supervision granted to the Department of Driver Services over driver improvement programs administered by nonprofit organizations under this Code section shall be limited to the establishment of minimum standards and requirements relative to the content of specific courses offered by such programs and relative to investigation and resolution of any complaints directed towards the content or operation of any course by a person enrolled in such course. The Department of Driver Services may adopt rules and regulations necessary to carry out the provisions of this subsection. The Department of Driver Services shall not require a nonprofit organization to obtain a license or permit or to pay a fee in order to administer a driver improvement program in the state.

The Department of Driver Services shall not require a commercial driving school licensed by such department to obtain an additional license to teach a defensive driving course, as described in subparagraph (b)(3)(A) or preparatory course offered to new drivers as described in paragraph (3) of subsection (c) of this Code section, at any location in this state.

Nothing in this Code section shall prevent an insurer from offering the reduction in premium specified in subsection (a) of this Code section to a driver who does not meet all of the requirements of subsection (b) or subsection (c), as applicable, of this Code section.

Section 33-9-43 - Reduction in premiums for motor vehicle liability, first-party medical, and collision coverage for named drivers under 25 years of age

For each personal or family-type policy of private passenger motor vehicle insurance issued, delivered, issued for delivery, or renewed, there shall be offered by the insurer a reduction in the premium for motor vehicle liability, first-party medical, and collision coverage for each named driver under 25 years of age, as listed on the policy application or provided in information subsequent to such application, of each motor vehicle covered by such policy, if that driver:

Is unmarried;

Is enrolled as a full-time student in:

High school;

Academic courses in a college or university; or

Vocational-technical school;

Is an honor student because the scholastic records for the immediately preceding quarter, semester, or comparable segment show that such person:

Ranks scholastically in the upper 20 percent of the class;

Has a "B" average or better;

Has a 3.0 average or better; or

Is on the "Dean's List" or "Honor Roll"; and

Is a driver whose use of the automobile is considered by the insurer in determining the applicable classification.

Proof of meeting the requirements for the discount provided by this Code section shall be provided annually to the insurer by the insured student or policyholder upon such forms as the Commissioner shall prescribe. The premium reduction required by this Code section shall be approved by the Commissioner and reflected in the insurer's automobile rating plan.

An insurer shall not be required to offer the premium reduction provided in subsection (a) of this Code section to a driver who, at any time within a period of three years prior to the beginning of the policy year during which that reduction is otherwise required, has:

Been involved in any motor vehicle accident in which that person has been determined to have been at fault;

Been finally convicted of, pleaded nolo contendere to, or been found to have committed a delinquent act constituting any of the following offenses:

Any serious traffic offense described in Article 15 of Chapter 6 of Title 40;

Any traffic offense for which three or more points may be assessed pursuant to Code Section 40-5-57; or

Any felony or any offense prohibited pursuant to Chapter 13 of Title 16, relating to dangerous drugs, marijuana, and controlled substances; or

Had that person's driver's license suspended for refusal to submit to chemical tests pursuant to Code Section 40-5-67.1 and that suspension has not been reversed, if appealed from.

Section 33-9-44 - Legislative intent

It is specifically intended that the discounts provided in Code Sections 33-9- 42 and 33-9-43 shall be provided by the insurer to any person who qualifies for such discounts.

Binders

Summary of Georgia State Law 33-24-33

This law pertains to **binders or temporary contracts for insurance**. Here are the key points:

Binders: These are temporary contracts for insurance that can be made either orally or in

writing. They are considered to include all the usual terms of the policy for which the binder was given, along with any applicable endorsements specified in the binder[1].

Validity Period: A binder is not valid beyond the issuance of the policy it was given for or beyond 90 days from its effective date, whichever is shorter. This rule does not apply to excess or surplus line insurance[1].

Extensions: If the policy has not been issued within the 90-day period, the binder can be extended or renewed with the written approval of the Commissioner or according to rules and regulations set by the Commissioner[1].

Exclusions: This section does not apply to life or accident and sickness insurance[1].

References: 33-24-33

Summary: This section defines binders and other contracts for temporary insurance, including their validity and terms.

Section 33-24-33 - Binders and other contracts for temporary insurance

Binders or other contracts for temporary insurance may be made orally or in writing and shall be deemed to include all the usual terms of the policy as to which the binder was given together with any applicable endorsements that are designated in the binder, except as superseded by the clear and express terms of the binder.

No binder shall be valid beyond the issuance of the policy with respect to which it was given or beyond 90 days from its effective date, whichever period is the shorter, provided that this subsection shall not apply to excess or surplus line insurance.

If the policy has not been issued, a binder may be extended or renewed beyond 90 days with the written approval of the Commissioner or in accordance with such rules and regulations relative thereto as the Commissioner may promulgate.

This Code section shall not apply to life or accident and sickness insurance.

Georgia Insurer Solvency Pool

Chapter 36: Georgia Insurers Insolvency Pool

33-36-1 to 33-36-12: This chapter establishes the Georgia Insurers Insolvency Pool, which provides protection to policyholders in the event of an insurer's insolvency.

The **Georgia Insurers Insolvency Pool** is a nonprofit legal entity created to protect policyholders when an insurance company becomes insolvent and can no longer pay its claims. Here are some key points about the Pool:

Purpose and Function

Primary Purpose: To ensure that claims are paid even if the insurance company that issued the policy goes bankrupt[1].

Coverage: It covers various types of claims, including workers' compensation, automobile accident claims, and other property and casualty insurance claims[1].

Structure and Management

Accounts: The Pool consists of three main accounts: workers' compensation, automobile, and all other covered insurance[2].

Responsibilities: It is responsible for investigating, adjusting, compromising, settling, and

paying covered claims. It also handles the management and investment of funds[2].

Funding

Assessments: Insurance companies operating in Georgia are required to pay into the Pool. These assessments ensure that there are sufficient funds available to cover claims when an insurer becomes insolvent[1].

Regulation

Supervision: The Pool operates under the supervision of the Georgia Insurance Commissioner and is subject to state insurance laws[2].

Impact on Policyholders

Claims Handling: When an insurer is declared insolvent, the Pool takes over the handling of claims. There may be a delay as the Pool processes and investigates these claims, but it aims to provide the same benefits as the original insurance company[1].

References: 33-36-1 through 12

Summary: These codes establish the Georgia Insurer Solvency Pool to protect policyholders in the event of an insurer's insolvency.

Section 33-36-1 - Short title

This chapter shall be known and may be cited as the "Georgia Insurers Insolvency Pool Act."

Section 33-36-2 - Creation; accounts; responsibility; supervision and regulation

There is created a Georgia Insurers Insolvency Pool which shall consist of three accounts:

workers' compensation account;

automobile account; and

all other covered insurance account. The pool shall be responsible for the investigation, adjustment, compromise, settlement, and payment of covered claims; for the investigation, handling, and denial of noncovered claims; and for the management and investment of funds administered by the pool. The members of the pool shall be responsible for the payment of assessments levied pursuant to subsection (b) of Code Section 33-36-7; for adherence to the rules of the plan approved pursuant to Code Section 33- 36-6; and for other obligations imposed by this chapter. The pool shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

Section 33-36-3 - Definitions

As used in this chapter, the term:

"Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

"Affiliate of the insolvent insurer" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

"Control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise unless the power is the result of an official position with or corporate office held by the

person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact and any person disputing his or her status as an affiliate of an insurer authorized to do business in Georgia or an insolvent insurer may file a disclaimer in accordance with subsection (i) of Code Section 33-13-4.

"Covered claim" means an unpaid claim which:

Arises out of a property or casualty insurance policy issued by an insurer which becomes an insolvent insurer which was authorized to do an insurance business in this state either at the time the policy was issued or when the insured event occurred; and

Is within any of the classes of claims under subparagraph (B) of this paragraph.

A claim shall not be paid unless it arises out of an insurable event under a property or casualty insurance policy and it is:

An unearned premium claim of a policyholder who at the time of the insolvency was a resident of this state;

An unearned premium claim of a policyholder under a policy affording coverage for property permanently situated in this state;

The claim of a policyholder or insured who at the time of the insured event was a resident of this state;

The claim of a person having an insurable interest in or related to property which was permanently situated in this state; or

A claim under a liability or workers' compensation insurance policy when either the insured or third-party claimant was a resident of this state at the time of the insured event.

A covered claim shall not include any claim in an amount of less than $50.00; provided, however, that any claim of $50.00 or more shall be paid in full.

A covered claim shall not include that portion of any first-party claim which is in excess of the applicable limits provided in the policy or $300,000.00, whichever is less.

A covered claim shall not include that portion of any third-party claim, other than a workers' compensation claim, which is in excess of the applicable limits provided in the policy or $300,000.00, whichever is less.

A covered claim shall not include any obligation to insurers, reinsurers, insurance pools, underwriting associations, health maintenance organizations, hospital plan corporations, or professional health service corporations as subrogation recoveries, reinsurance recoveries, contribution, indemnification, or otherwise. No such claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, or professional health service corporation may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent such claim exceeds the pool obligation limitations set forth in this Code section.

A covered claim shall not include any first-party claim by an insured whose net worth exceeds $10 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer; provided, however, that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; or any third-party claim relating to a policy of an insured

whose net worth exceeds $25 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer; provided, however, that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; and further provided that this exclusion shall not apply to third-party claims against the insured where the insured has applied for or consented to the appointment of a receiver, trustee, or liquidator for all or a substantial part of its assets, filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law or, if an order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

A covered claim shall not include any first-party claims by an insured which is an affiliate of the insolvent insurer.

A covered claim shall not include any claim or judgment for punitive damages and attorney's fees associated therewith against any insolvent insurer, its insured, or the insurers insolvency pool.

A covered claim shall not include any workers' compensation benefits payable under subsection (e) or (f) of Code Section 34-9-221 or paragraph (2), (3), or (4) of subsection (b) of Code Section 34-9-108 after the effective date of the court order of rehabilitation or liquidation.

A covered claim shall include a claim for unearned premium only if such claim derives from the payment of a stated premium and shall not include those which derive from an unstated premium such as calculated from audit, dividend, deposit, or retrospect plans. Further, a covered claim shall not include:

That portion of a claim for unearned premium which is in excess of $20,000.00; or

A claim for unearned premium resulting from a policy which was not in force on the date of the final order of liquidation.

A covered claim shall not include any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent.

A covered claim shall not include any fee or other amount sought by or on behalf of an attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the pool.

However, in such a case, the pool shall not offset amounts from any recovery paid to a claimant in such an action which the claimant has agreed are to be paid to the attorney in a contingency fee arrangement.

A covered claim shall not include any claims for interest.

Notwithstanding any other provision of this chapter, an insurance policy issued by a member insurer and later allocated, transferred, or assumed by, or otherwise made the sole responsibility of another insurer, pursuant to any provision of law of this state providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity, shall be considered to have been issued by a member insurer which is an insolvent insurer for the purposes of this chapter in the event that the insurer to which the policy has been allocated, transferred, assumed by, or otherwise made the sole responsibility of is placed in liquidation.

An insurance policy that was issued by a nonmember insurer and later allocated, transferred, assumed by, or otherwise made the sole responsibility of a member insurer under any provision of law of this state described in subparagraph (O) of this paragraph shall not be considered to have been issued by a member insurer for the purposes of this chapter.

"Insolvent insurer" means an insurer which was licensed to issue property or casualty insurance policies in this state at any time subsequent to July 1, 1970, and against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile or of this state and which order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

"Insolvency pool" or "pool" means the Georgia Insurers Insolvency Pool established pursuant to Code Section 33-36-2.

"Insured" means any named insured, any additional insured, any vendor, any lessor, or any other party identified as an insured under the policy as long as insurable interests remain relevant.

"Insurer" or "company" means any corporation or organization that has held or currently holds a license to engage in the writing of property or casualty insurance policies in this state, including the exchanging of reciprocal or interinsurance contracts among individuals, partnerships, and corporations, except farmer assessment mutual insurers, county assessment mutual insurers, and municipal assessment mutual insurers.

"Net direct written premiums" means direct gross premiums written on property or casualty insurance policies, less return premiums on the policies and dividends paid or credited to policyholders on such direct business. Premiums written by any authorized insurer on policies issued to self-insurers, whether or not designated as reinsurance contracts, shall be deemed net direct written premiums.

"Person" means any individual or legal entity, including governmental entities.

"Property and casualty insurance policies" or "policy" means any contract, including endorsements to such contract and without regard to the nature or form of the contract or endorsement, which provides coverages as enumerated in Code Sections 33-7-3 and 33-7-6, except:

Life insurance and annuities (being that class of insurance referred to in Code Section 33-7-4);

Accident, health, and disability insurance except where written as part of an automobile insurance contract (being that class of insurance referred to in Code Section 33-7-2);

Title insurance (being that class of insurance referred to in Code Section 33-7-8);

Credit life insurance (being that class of insurance referred to in paragraph (2) of Code Section 33-31-1);

Credit insurance, vendors' single interest insurance, or collateral protection insurance, or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks;

Fidelity or surety bonds or any other bonding obligations;

Insurance of warranties or service contracts including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement, or

service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

Ocean marine insurance;

Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by the transfer of insurance risk; or

Any insurance provided by or guaranteed by government. Section 33-36-4 - Insurers Solvency Board

There shall be a board of trustees of the Georgia Insurers Insolvency Pool which shall be known as the Insurers Solvency Board and which shall consist of seven members. At all times, the board shall contain at least one member from a domestic insurer. The members of the board shall not be considered employees of the department. The members of the board shall be selected by the Commissioner. Each board member so selected shall represent a company licensed to do business in Georgia. Any member may be removed from office by the Commissioner when, in his or her judgment, the public interest may so require. Each member appointed shall serve for a term of three years and until his or her successor has been appointed and qualified and, in case of a vacancy for any reason in the office of any such member, the Commissioner shall appoint a member to fill the unexpired term of such vacant office.

In approving selections to the board, the Commissioner shall consider among other things whether all member insurers are fairly represented.

The actual expenses of the members of the board incurred in attending meetings shall be paid out of the assets of the insolvency pool, but members of the board shall not otherwise be compensated by the pool for their services. For the purpose of considering questions before it, the board shall have access to all the books, records, reports, and papers in the department, including all confidential communications; and the members of the board shall treat such communications as confidential.

Section 33-36-5 - Insurers required to become members of pool

Every insurer authorized to write property or casualty insurance policies in this state shall be a member of the insolvency pool and shall be liable for assessments pursuant to Code Section 33-36-7 and shall also be responsible for the other obligations imposed pursuant to this chapter.

Section 33-36-6 - Plan to govern members; rules; requirements for plan; assignment of claims or judgments against insolvent insurers; claimants of assets of insolvent insurers; jurisdiction; venue

The Georgia Insurers Insolvency Pool is a nonprofit legal entity with the right to bring and defend actions and such right to bring and defend actions includes the power and right to intervene as a party before any court in this state that has jurisdiction over an insolvent insurer as defined in this chapter. The pool shall adopt, and the Commissioner shall approve, a reasonable plan which is not inconsistent with this chapter, and which is fair to insurers and equitable to their policyholders, pursuant to which all admitted insurers shall become members of the pool. All members of the pool shall adhere to the rules of the plan. The plan may be amended by an affirmative vote of a majority of the Insurers Solvency Board.

If, for any reason, the pool fails to adopt a suitable plan, or if, at any time, the pool fails to adopt

necessary amendments to the plan, the Commissioner shall adopt and promulgate, after a hearing, such reasonable rules as are necessary to effectuate this chapter. The rules shall continue in force until modified by the Commissioner or superseded by a plan of operation adopted by the pool and approved by the Commissioner.

The plan as provided for in subsection (a) of this Code section shall:

Establish the procedures whereby all the powers and duties of the pool under this chapter will be performed;

Establish procedures for handling assets of the pool;

Mandate that procedures be established for the disposition of liquidating dividends or other moneys received from the estate of the insolvent insurer;

Mandate that procedures be established to designate the amount and method of reimbursing members of the board of trustees under Code Section 33-36-4;

Establish procedures by which claims may be filed with the pool and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the pool or its agent and a list of claims shall be periodically submitted to the pool or insolvency fund or its equivalent in another state by the receiver or liquidator;

Establish regular places and times for meetings of the board of trustees;

Mandate that procedures be established for records to be kept of all financial transactions of the pool, its agents, and the board of trustees;

Establish the procedures whereby selections for the board of trustees will be submitted to the Commissioner; and

Contain additional provisions necessary or proper for the execution of the powers and duties of the pool.

In accordance with the plan, the pool may designate insurers to act on behalf of the pool to carry out the purposes of this chapter, but a member may decline such designation. The Commissioner may disapprove such designation. The plan may provide a procedure under which pending claims or judgments against the insolvent insurer or its insureds are assigned to the member companies designated to act for the pool. The assignee-insurer is authorized to appear and defend a claim in a court of competent jurisdiction or otherwise and to investigate, adjust, compromise, and settle a covered claim or to investigate, handle, and deny a noncovered claim, and to do so on behalf of and in the name of the pool. If an assignee-insurer pays the covered claim, it shall be reimbursed by the pool or be entitled to set off said payment against future assessments. The unreimbursed claim of such an insurer against the pool shall be an admitted asset of the insurer. Insureds entitled to protection of this chapter shall cooperate with the pool and the assignee-insurer.

The pool as a legal entity and any of its individual members shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer and except as otherwise provided in this chapter. The pool shall be subrogated to the rights of any insured or claimant, to the extent of a covered claim, to participate in the distribution of assets of the insolvent insurer to the extent that the pool has made payment.

Any claimant or insured entitled to the benefits of this chapter shall be deemed to have assigned

to the pool, to the extent of any payment received, his or her rights against the estate of the insolvent insurer. After determination of insolvency of any insurer, the pool shall be a party in interest in all proceedings involving policies insured or assumed by the pool with the same rights to receive notice and defend, appeal, and review as the insolvent insurer would have had if solvent. All moneys recovered under this Code section or any other Code section shall be added to the assessments collected under Code Section 33-36-7.

Except for actions by member insurers aggrieved by final actions or decisions of the pool pursuant to Code Section 33-36-18, all actions relating to or arising out of this chapter against the pool must be brought in the courts in this state. Such courts shall have exclusive jurisdiction over all actions relating to or arising out of this chapter against the pool.

Exclusive venue in any action by or against the pool is in the Superior Court of DeKalb County. The pool may, at the option of the pool, waive such venue as to specific actions.

Section 33-36-7 - Levy of assessments against insurers; reimbursement of expenses; refunds of assessments

For the purposes of administration and assessment under this Code section, the pool shall be divided into three separate accounts:

workers' compensation insurance account;

automobile insurance account; and

all other covered insurance account. Separate assessment shall be made for each account. No assessment shall be levied for any account as long as the assets held in such account are sufficient to cover all estimated payments for liquidation in process under the account.

To the extent necessary to secure the funds for the respective accounts of the pool for the payment of covered claims and also to pay the reasonable costs to administer the pool, the Commissioner, upon certification of the pool, shall levy assessments in the proportion that each insurer's net direct written premiums in this state in the classes protected by the account bear to the total of the net direct written premiums received in this state by all such insurers for the preceding calendar year for the kinds of insurance included within such account. Assessments shall be remitted to and administered by the pool in the manner specified by the approved plan.

Each insurer so assessed shall have at least 30 days' written notice as to the date the assessment is due and payable. Every assessment shall be made as a uniform percentage applicable to the net direct written premiums of each insurer in the kinds of insurance included within the account in which the assessment is made. The assessments levied against any insurer shall not exceed in any one year more than 2 percent of that insurer's net direct written premiums in this state for the kinds of insurance included within such account during the calendar year next preceding the date of such assessments. If sufficient funds from the assessments, together with funds previously raised, are not available in any one year in the respective account to make all the payments or reimbursements then owing to insurers designated to act for the pool, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available.

The pool may exempt any insurer from an assessment if an assessment by the pool would result in the insurer's financial statement reflecting an amount of capital or surplus less than the sum of the minimum amount required by any jurisdiction in which the insurer is authorized to transact insurance.

Any necessary and proper expenses incurred by an insurer in the investigation, adjustment,

compromise, settlement, denial, or handling of claims assigned to it shall, upon proper verification under the rules of the pool, entitle the insurer to reimbursement. Any insurer whose employee serves on the staff of the pool may set off from its assessment any necessary and proper expenses incurred by the insurer resulting from said service of its employee.

An insurer which ceases to engage in the business of writing property or casualty insurance policies in this state shall have no right to a refund of any assessment previously remitted to the pool.

Section 33-36-7.1 - Surcharge on premiums to recoup assessments; disclosure to insureds; excess surcharges, exception where the expense of collection would exceed the amount of the surcharge

The plan adopted pursuant to Code Section 33-36-6 shall contain provisions whereby each member insurer is required to recoup over the year following the year of the assessment a sum calculated to recoup the assessments paid by the member insurer under this chapter by way of a surcharge on premiums charged for insurance policies to which this chapter applies. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax or agents' commission.

The amount of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. Member insurers who collect surcharges in excess of assessments paid pursuant to Code Section 33- 36-7 for an insolvent insurer shall remit the excess to the pool as an additional assessment within 30 days after the pool has determined the amount of the excess recoupment and given notice to the member of that amount. The excess shall be applied to reduce future assessment charges in the appropriate category.

The plan of operation may permit a member insurer to omit collection of the surcharge from its insureds when the expense of collecting the surcharge would exceed the amount of the surcharge. However, nothing in this Code section shall relieve the member insurer of its obligation to recoup the amount of surcharge otherwise collectable.

Section 33-36-8 - Issuance by Commissioner of notice of judicial determination of insolvency of insurer; requirement of notification of insureds by agents of insurer; publication of notice

Upon the determination of a court of competent jurisdiction of the state of domicile of an insurer that the insurer is insolvent, the Commissioner of this state shall promptly give notice of the insurer's insolvency by first-class mail to all persons known or reasonably expected to have or be interested in claims against the insurer at such person's last known address, all insureds of the insolvent insurer known to the Commissioner at such insured's last known address, and all insurers subject to this chapter. The Commissioner may also require each agent of the insolvent insurer to give prompt written notice by first-class mail at the insured's last known address to each insured of the insolvent insurer for whom he was agent of record.

Notice shall also be given by publication in a newspaper of general circulation published in the county where the insurer had its principal office not less than once per week for four weeks and by publication elsewhere in this state as the court may direct.

Section 33-36-9 - Coverage afforded by insolvent insurers to become obligation of pool; investigation and settlement of claims by pool

In the event an insurer is ordered to be liquidated, the coverage afforded by property and casualty insurance policies issued by such insurer shall, with respect to covered claims, become the obligation of the pool for a period of 30 days from the date of such determination or until

policy expiration date if less than said 30 days or until the policy has been replaced by the insurer within said 30 days. The pool shall be deemed the insurer only to the extent of its obligation on the covered claims and to such extent, subject to the limitations provided in this chapter, shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including, but not limited to, the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations. The pool shall not be deemed the insolvent insurer for any purpose relating to the issue of whether the pool is amenable to the personal jurisdiction of the courts of any state. The pool is authorized to investigate, adjust, compromise, and settle covered claims or to investigate, handle, and deny noncovered claims. The pool shall have the authority, upon approval of the Commissioner, to borrow funds necessary to effect the purposes of this chapter. The pool shall have the authority to establish procedures for requesting financial information from insureds on a confidential basis for purposes of applying Code sections concerning their net worth, subject to such information being shared with any other association similar to the pool and the liquidator for the insolvent company on the same confidential basis. If the insured refuses to provide the requested financial information and an auditor's certification of the same where requested and available, the pool may deem the net worth of the insured, in the instance of a first-party claim, to be in excess of $10 million at the relevant time or, in the event of a third- party claim, to be in excess of $25 million at the relevant time. In any lawsuit contesting the applicability of subparagraph (G) of paragraph (4) of Code Section 33-36-3 or subsection (d) of Code Section 33-36-14 where the insured has declined to provide financial information under the procedure provided pursuant to this Code section, the insured shall bear the burden of proof concerning its net worth at the relevant time.

If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the pool its full costs, expenses, and reasonable attorney's fees in contesting the claim.

Section 33-36-10 - Recovery under chapter of covered claims recoverable under insolvency funds of other states

It is not the purpose of this chapter to provide or permit duplicate recoveries of covered claims under this chapter and an insolvency fund or its equivalent of any other state. In the construction and application of this chapter with respect to a covered claim which may be recoverable under this chapter and under an insolvency fund or its equivalent in another state, the sole recovery:

with respect to a workers' compensation claim, shall be under the insolvency fund or its equivalent of the state of residence of the claimant;

with respect to a first-party claim of an insured for damage to or destruction of property with a permanent location, shall be under the insolvency fund or its equivalent of the state where the property is permanently situated; and

with respect to any other covered claim, shall be under the insolvency fund or its equivalent of the state of residence of the insured.

Any recovery obtained from the pool pursuant to this chapter shall be reduced by those amounts recovered in any other state from a similar or equivalent insolvency fund in such state when the recovery was obtained by the same claimant for the same claim filed against the pool in this state.

Section 33-36-11 - Limitation for filing claims; claims filed after final date set by court; default judgments

Notwithstanding any other provisions of this chapter, except as provided for in Code Section 33-36-20, a covered claim shall not include a claim filed with the pool after the earlier of (1) 18 months after the date of the order of liquidation, or (2) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer and shall not include any claim filed with the pool or a liquidator for protection afforded under the insured's policy for incurred but not reported losses.

The pool may not be found in default. No default judgments may be entered against the pool, the insolvent insurer, or the insured of the insolvent insurer after the instigation of an insolvency proceeding prior to an order of liquidation, nor during the pendency of insolvency proceedings, nor during a 120 day stay following an order of liquidation.

In no instance may a finding of default or the entry of a default judgment against an insurer be applicable or enforceable against the pool or the insured of the insolvent insurer.

Section 33-36-12 - Powers and duties of Commissioner as to collection of assessments; judicial review

The Commissioner shall bring an action for and recover, on behalf of the pool, any assessment not paid when due. He may, after notice and hearing, revoke the certificate of authority to transact business in this state of an insurer who is a member of the pool which fails to pay an assessment when due as provided in this chapter and after demand having been made or which otherwise fails to comply with the plan as approved pursuant to Code Section 33-36-6. Any action taken by the Commissioner shall be subject to judicial review as provided in Code Sections 33-2-26 through 33- 2-28.

Georgia Rules and Codes Pertinent to Personal Lines Only

Georgia state law sections 33-33-1 through 33-33-8 pertain to the establishment and operation of the Fair Access to Insurance Requirements (FAIR) Plan. Here's a brief summary:

33-33-1: Establishes the FAIR Plan and underwriting association, allowing insurers to provide property insurance to those who cannot obtain it through the regular market. This plan is subject to approval and regulation by the Commissioner of Insurance[1].

33-33-2: Defines the terms used within the chapter, such as "association," "plan," and "insurer"[1].

33-33-3: Details the requirements for the FAIR Plan, including the need for insurers to participate and the process for formulating and amending the plan[1].

33-33-4: Outlines the powers and duties of the underwriting association, including the ability to assess members for expenses and losses[1].

33-33-5: Specifies the procedures for applying for insurance under the FAIR Plan and the criteria for eligibility[1].

33-33-6: Describes the process for handling claims and the responsibilities of the association in managing these claims[1].

33-33-7: Provides guidelines for the financial operations of the association, including the handling of funds and financial reporting[1].

33-33-8: Addresses the penalties for non-compliance with the provisions of the FAIR Plan[1].

These sections collectively ensure that property insurance is accessible to all residents, even

those who might otherwise struggle to obtain coverage.

FAIR Plan

References: 33 33-1 through 8

Summary: The FAIR Plan provides insurance coverage for properties that are difficult to insure through the standard market.

Section 33-33-1 - Establishment of Fair Access to Insurance Requirements Plan and underwriting association

All insurers licensed to write and writing property insurance in this state on a direct basis are authorized, subject to approval and regulation by the Commissioner, to establish and maintain a Fair Access to Insurance Requirements (FAIR) Plan and to establish and maintain an underwriting association and to formulate and from time to time amend the plan and articles of association and rules and regulations in connection therewith and to assess and share on a fair and equitable basis all expenses, income, and losses incident to the Fair Access to Insurance Requirements Plan and underwriting association in a manner consistent with this chapter.

Section 33-33-2 - Requirements of plan and articles of association

The Fair Access to Insurance Requirements Plan and articles of association shall make provision for an underwriting association having authority on behalf of its members to cause to be issued property insurance policies, to reinsure in whole or in part any such policies, and to cede any such reinsurance.

The plan and articles of association shall provide, among other things, for the perils to be covered; geographical area of coverage; compensation and commissions; assessments of members; the sharing of expenses, income, and losses on an equitable basis; cumulative weighted voting for the board of directors of the association; the administration of the plan and association; and any other matter necessary or convenient for the purpose of assuring fair access to insurance requirements.

Section 33-33-3 - Requirement of participation in plan by property insurers

Each insurer authorized to write and writing property insurance in this state shall be required to become and remain a member of the plan and the underwriting association and to comply with the requirements of the plan and the underwriting association as a condition of its authority to transact property insurance business.

Each insurer shall participate in the writings, expenses, profits, and losses of the association in the following manner:

For habitational risks, the same proportion as its habitational premiums written bear to the aggregate habitational premiums written by all insurers in the program; and

For commercial risks, the same proportion as its commercial premiums written bear to the aggregate commercial premiums written by all insurers in the program.

Section 33-33-4 - Powers of Commissioner generally

The directors of the association shall submit to the Commissioner, for review, a proposed Fair Access to Insurance Requirements Plan and articles of association consistent with this chapter.

The Fair Access to Insurance Requirements Plan and articles of association shall be subject to approval by the Commissioner and shall take effect ten days after having been approved by the Commissioner. If the Commissioner disapproves all or any part of the proposed plan and

articles, the directors of the association shall within 30 days submit for review an appropriately revised plan and articles; and, if the directors fail to do so, the Commissioner shall thereafter promulgate such plan and articles consistent with this chapter.

The directors of the association may, on their own initiative or at the request of the Commissioner, amend the plan and articles, subject to approval by the Commissioner.

Section 33-33-5 - Modification by insurers of rates

In conformity with Chapter 9 of this title, insurers may make reasonable rate modifications for fire and extended coverage and such other classes of basic property insurance.

Section 33-33-6 - Liability for inspections and statements

There shall be no liability on the part of, and no cause of action of any nature shall arise against, insurers, any inspection bureau, placement facility, or underwriting association, or their directors, agents, or employees, or the Commissioner or his or her authorized representatives for any inspections undertaken or statements made by any of them concerning the property to be insured; and any reports and communications in connection therewith shall not be considered public documents.

Section 33-33-7 - Appeals from actions or decisions

Any person aggrieved by any action or decision of the administrators of the plan, the underwriting association, or of any insurer as a result of its participation in the plan may appeal to the Commissioner within 30 days from the date of the action or the decision. The Commissioner, after a hearing held upon proper notice, shall issue an order approving the action or decision or disapproving the action or decision with respect to the matter which is the subject of appeal. All final orders and decisions of the Commissioner shall be subject to judicial review as provided in Chapter 2 of this title.

Section 33-33-8 - Temporary insurance coverage for local public entity filing appeal of adverse underwriting decision

For the purposes of this Code section, the term "local public entity" means a county, municipality, or local board of education.

In the event the insurance coverage of a local public entity filing an appeal of an adverse underwriting decision of the association established pursuant to this chapter is scheduled to cancel or expire while such appeal is pending, the Commissioner shall direct the association to provide coverage authorized under this chapter on a temporary basis to the local public entity as provided in this Code section.

It shall be the duty of the local public entity to notify the Commissioner in writing at the same time the appeal is filed of the date its existing insurance coverage is to cancel or expire. Failure of the local public entity to notify the Commissioner as provided in this subsection shall render the local public entity ineligible for the temporary coverage authorized by this Code section. Upon receiving such notice, the Commissioner shall direct the association to provide coverage authorized under this chapter to the local public entity, shall specify the date such coverage is to be effective, and shall specify the date of termination of such coverage, which shall not be set prior to the date of the Commissioner's final order disposing of the issues on appeal. The premium for the temporary coverage provided by this Code section shall be paid in full by the local public entity at the time the coverage is issued by such method and in such manner as directed by the Commissioner.

Upon receipt of the notice from the public entity specified in subsection

(c) of this Code section, the Commissioner shall notify such entity of the emergency property protection measures, if any, which will be required during the period of temporary coverage. Such measures may include the following:

Protection of physically damaged property from further damage;

Prevention or limitation of access to the premises;

Disconnection of utilities;

Installation of locks, alarms, or security lighting;

Inspections of the premises; or

Provision of security guards.

After ordering the temporary coverage required under subsection (b) of this Code section, the Commissioner shall cause notice of such action and any emergency protection measures pertaining to such coverage to be published in the legal organ of the county in which the property is located.

Auto

Here's a summary of the specified Georgia state laws and regulations:

Georgia State Law 33-9-42

Premium Reductions: Insurers must offer a reduction of at least 10% in premiums for motor vehicle liability, first-party medical, and collision coverages if all named drivers on the policy meet certain criteria, such as having no traffic offenses or claims for the prior three years and completing an approved defensive driving course[12].

Georgia State Law 33-7-11

Uninsured Motorist Coverage: All motor vehicle liability policies issued in Georgia must include uninsured motorist coverage. This coverage compensates the insured for bodily injury, loss of consortium, death, or property damage caused by an uninsured motorist. The minimum coverage limits are $25,000 per person and $50,000 per accident for bodily injury, and $25,000 for property damage[34].

Georgia State Laws 40-9-1 through 40-9-12

Motor Vehicle Safety Responsibility Act: This set of laws requires drivers to report accidents and provide proof of financial responsibility. It includes provisions for the suspension of driver's licenses for failure to provide such proof and outlines the penalties for violations[56].

Georgia State Laws 40-9-80 through 40-9-8

Operating During Suspension: It is a misdemeanor to operate a vehicle while the driver's license is suspended under this chapter. Penalties include imprisonment for 5 to 6 months and a fine up to $500[78].

Georgia State Law 33-34-4

Mandatory Insurance: Vehicle owners must have motor vehicle liability insurance equivalent to the coverage required under the Motor Vehicle Safety Responsibility Act. This ensures coverage for bodily injury and property damage liability[910].

Georgia Insurance Rules and Regulations 120-2-14.02 through 120-2-14.09

Georgia Automobile Insurance Plan: These regulations govern the Georgia Automobile Insurance Plan, which provides insurance to high-risk drivers who cannot obtain coverage through ordinary methods. The rules cover eligibility, application procedures, and the operation of the plan[1112].

Georgia State Law 40-9-100

Assigned Risk Plan: The Commissioner of Insurance must approve a plan for the equitable distribution of high-risk applicants among insurance companies. This plan ensures that drivers who are unable to obtain insurance through regular channels can still get coverage. Appeals can be made to the Commissioner regarding decisions under this plan[1314].

Defensive Driving

References: 33-9-42

Summary: This regulation provides for discounts on auto insurance premiums for drivers who complete a defensive driving course.

Section 33-9-42 - Reduction in premiums for motor vehicle liability, first-party medical, and collision coverages for certain named drivers

For each personal or family-type policy of private passenger motor vehicle insurance issued or issued for delivery in this state, there shall be offered by the insurer a reduction of not less than 10 percent in premiums for motor vehicle liability, first-party medical, and collision coverages to the policyholder if all named drivers, as listed or who should be listed on the policy application or provided in information subsequent to such application, of each motor vehicle covered by such policy satisfy the requirements of subsection (b) or subsection (c), as applicable, of this Code section.

Reductions in premiums shall be available if all named drivers who are 25 years of age or older:

Have committed no traffic offenses for the prior three years or since the date of licensure, whichever is shorter;

Have had no claims based on fault against an insurer for the prior three years; and

Complete one of the following types of driving courses:

A defensive driving course of not less than six hours from a driver improvement clinic or commercial or noncommercial driving school approved by and under the jurisdiction of the Department of Driver Services;

An emergency vehicles operations course at the Georgia Public Safety Training Center;

A defensive driving course of not less than six hours from a driver improvement program which is administered by a nonprofit organization such as the AARP, the American Automobile Association, the National Safety Council, or a comparable organization and which meets the rules and regulations of the Department of Driver Services pursuant to subsection (g) of this Code section; or

A defensive driving course of not less than six hours which is offered by an employer to its employees and their immediate families and which meets the rules and regulations of the Department of Driver Services.

Reductions in premiums shall be available if all named drivers who are under 25 years of age:

Have committed no traffic offenses for the prior three years or since the date of licensure, whichever is shorter;

Have had no claims based on fault against an insurer for the prior three years; and

Complete a preparatory course offered to new drivers of not less than 30 hours of classroom training and not less than six hours of practical training by a driver's training school approved by and under the jurisdiction of the Department of Driver Services or by an accredited secondary school, junior college, or college.

Upon completion of one of the defensive driving courses specified in paragraph (3) of subsection (b) or preparatory courses offered to new drivers specified in paragraph (3) of subsection (c), as applicable, of this Code section by each named driver, eligibility for reductions in premiums for such policy shall continue for a period of three years, provided any named driver under such policy does not commit a traffic offense or have a claim against the policy based on any such driver's fault.

The Department of Driver Services shall assure through the supervision of driver improvement clinics, emergency vehicles operations courses, driver improvement programs administered by nonprofit organizations, and commercial or noncommercial driving schools approved by the Department of Driver Services that defensive driving courses shall be available and accessible wherever practicable as determined by the department to licensed drivers throughout the state.

Each insurer providing premium discounts under this Code section shall provide, upon the request of the Commissioner, information regarding the amount of such discounts in a form acceptable to the Commissioner.

The power of supervision granted to the Department of Driver Services over driver improvement programs administered by nonprofit organizations under this Code section shall be limited to the establishment of minimum standards and requirements relative to the content of specific courses offered by such programs and relative to investigation and resolution of any complaints directed towards the content or operation of any course by a person enrolled in such course. The Department of Driver Services may adopt rules and regulations necessary to carry out the provisions of this subsection. The Department of Driver Services shall not require a nonprofit organization to obtain a license or permit or to pay a fee in order to administer a driver improvement program in the state. The Department of Driver Services shall not require a commercial driving school licensed by such department to obtain an additional license to teach a defensive driving course, as described in subparagraph (b)(3)(A) or preparatory course offered to new drivers as described in paragraph (3) of subsection (c) of this Code section, at any location in this state.

Nothing in this Code section shall prevent an insurer from offering the reduction in premium specified in subsection (a) of this Code section to a driver who does not meet all of the requirements of subsection (b) or subsection (c), as applicable, of this Code section.

Uninsured Motorists Coverage References: 33-7-11

Summary: This section mandates the provision of uninsured motorist coverage in auto insurance policies.

Section 33-7-11 - Uninsured motorist coverage under motor vehicle liability policies

No automobile liability policy or motor vehicle liability policy shall be issued or delivered in this state to the owner of such vehicle or shall be issued or delivered by any insurer licensed in this state upon any motor vehicle then principally garaged or principally used in this state unless it contains an endorsement or provisions undertaking to pay the insured damages for bodily injury, loss of consortium or death of an insured, or for injury to or destruction of property of an insured under the named insured's policy sustained from the owner or operator of an uninsured motor vehicle, within limits exclusive of interests and costs which at the option of the insured shall be:

Not less than $25,000.00 because of bodily injury to or death of one person in any one accident, and, subject to such limit for one person,

$50,000.00 because of bodily injury to or death of two or more persons in any one accident, and $25,000.00 because of injury to or destruction of property; or

Equal to the limits of liability because of bodily injury to or death of one person in any one accident and of two or more persons in any one accident, and because of injury to or destruction of property of the insured which is contained in the insured's personal coverage in the automobile liability policy or motor vehicle liability policy issued by the insurer to the insured if those limits of liability exceed the limits of liability set forth in subparagraph (A) of this paragraph. In any event, the insured may affirmatively choose uninsured motorist limits in an amount less than the limits of liability.

The coverages for bodily injury or death or for injury to or destruction of property of an insured person, as provided in paragraph (1) of this subsection, may be subject to deductible amounts as follows:

For bodily injury or death, deductibles of $250.00, $500.00, or $1,000.00, at the option of any named insured in the policy. Deductibles above $1,000.00 may be offered, subject to approval of the Commissioner;

For injury to or destruction of property of the insured, deductibles of $250.00, $500.00, or $1,000.00, at the option of any named insured in the policy. Deductibles above $1,000.00 may be offered, subject to the approval of the Commissioner;

Deductible amounts shown in subparagraphs (A) and (B) of this paragraph may not be reduced below $250.00;

Deductible amounts shown in subparagraphs (A) and (B) of this paragraph shall be made available at a reduced premium; and

Where an insurer has combined into one single limit the coverages required under paragraph (1) of this subsection, any deductible selected under subparagraphs (A) and (B) of this paragraph shall be combined, and the resultant total shall be construed to be a single aggregate deductible.

The coverage required under paragraph (1) of this subsection shall not be applicable where any insured named in the policy shall reject the coverage in writing. The coverage required under paragraph (1) of this subsection excludes umbrella or excess liability policies unless affirmatively provided for in such policies or in a policy endorsement. The coverage need not be provided in or supplemental to a renewal policy where the named insured had rejected the coverage in connection with a policy previously issued to said insured by the same insurer. The amount of coverage need not be increased from the amounts shown on the declarations page on renewal once coverage is issued.

The filing of a petition for relief in bankruptcy under a chapter of Title 11 of the United States Code by an uninsured motorist as described in this Code section, or the appointment of a trustee in bankruptcy for an uninsured motorist as described in this Code section, or the discharge in bankruptcy of an uninsured motorist as described in this Code section shall not affect the legal liability of an uninsured motorist as the term "legal liability" is used in this Code section, and such filing of a petition for relief in voluntary or involuntary bankruptcy, the appointment of a trustee in bankruptcy, or the discharge in bankruptcy of such an uninsured motorist shall not be pleaded by the insurance carrier providing uninsured motorist protection in bar of any claim of an insured as defined in this Code section so as to defeat payment for damages sustained by any insured by the insurance company providing uninsured motorist protection and coverage under the terms of this chapter; but the insurance company or companies shall have the right to defend any such action in its own name or in the name of the uninsured motorist and shall make payment of any judgment up to the limits of the applicable uninsured motorist insurance protection afforded by its policy. In those cases, the uninsured motorist upon being discharged in bankruptcy may plead the discharge in bankruptcy against any subrogation claim of any uninsured motorist carrier making payment of a claim or judgment in favor of an uninsured person, and the uninsured motorist may plead said motorist's discharge in bankruptcy in bar of all amounts of an insured person's claim in excess of uninsured motorist protection available to the insured person.

As used in this Code section, the term:

"Bodily injury" shall include death resulting from bodily injury.

"Insured" means the named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle or otherwise; any person who uses, with the expressed or implied consent of the named insured, the motor vehicle to which the policy applies; a guest in such motor vehicle to which the policy applies; or the personal representatives of any such persons. The term "insured" shall also mean a foster child or ward residing in the household of the named insured pursuant to a court order, guardianship, or placement by the department of family and children services or other department or agency of the state, while in a motor vehicle or otherwise.

"Property of the insured" as used in subsection (a) of this Code section means the insured motor vehicle and includes the personal property owned by the insured and contained in the insured motor vehicle.

"Uninsured motor vehicle" means a motor vehicle, other than a motor vehicle owned by or furnished for the regular use of the named insured, the spouse of the named insured, and, while residents of the same household, the relative of either, as to which there is:

No bodily injury liability insurance and property damage liability insurance;

Bodily injury liability insurance and property damage liability insurance and the insured has uninsured motorist coverage provided under the insured's motor vehicle insurance policy; the motor vehicle shall be considered uninsured, and the amount of available coverages shall be as follows:

Such motor vehicle shall be considered uninsured to the full extent of the limits of the uninsured motorist coverage provided under the insured's motor vehicle insurance policies, and such coverages shall apply to the insured's losses in addition to the amounts payable under any available bodily injury liability and property damage liability insurance coverages. The insured's uninsured motorist coverage shall not be used to duplicate payments made under any available

bodily injury liability insurance and property damage liability insurance coverages but instead shall be available as additional insurance coverage in excess of any available bodily injury liability insurance and property damage liability insurance coverages; provided, however, that the insured's combined recovery from the insured's uninsured motorist coverages and the available coverages under the bodily injury liability insurance and property damage liability insurance on such uninsured motor vehicle shall not exceed the sum of all economic and noneconomic losses sustained by the insured. For purposes of this subdivision, available coverages under the bodily injury liability insurance and property damage liability insurance coverages on such motor vehicle shall be the limits of coverage less any amounts by which the maximum amounts payable under such limits of coverage have, by reason of payment of other claims or otherwise, been reduced below the limits of coverage;

Provided, however, that an insured may reject the coverage referenced in subdivision (I) of this division and select in writing coverage for the occurrence of sustaining losses from the owner or operator of an uninsured motor vehicle that considers such motor vehicle to be uninsured only for the amount of the difference between the available coverages under the bodily injury liability insurance and property damage liability insurance coverages on such motor vehicle and the limits of the uninsured motorist coverages provided under the insured's motor vehicle insurance policies; and, for purposes of this subdivision, available coverages under the bodily injury liability insurance and property damage liability insurance coverages on such motor vehicle shall be the limits of coverage less any amounts by which the maximum amounts payable under such limits of coverage have, by reason of payment of other claims or otherwise, been reduced below the limits of coverage; and

Neither coverage under subdivision (I) nor (II) of this division shall be applicable if the insured rejects such coverages as provided in paragraph

(3) of subsection (a) of this Code section.

The coverage set forth in subdivision (I) of this division need not be provided in or supplemental to a renewal policy where the named insured has rejected the coverage set forth in subdivision (I) of this division and selected the coverage set forth in subdivision (II) of this division in connection with a policy previously issued to said insured by the same insurer;

Bodily injury liability insurance and property damage liability insurance in existence but the insurance company writing the insurance has legally denied coverage under its policy;

Bodily injury liability and property damage liability insurance in existence but the insurance company writing the insurance is unable, because of being insolvent, to make either full or partial payment with respect to the legal liability of its insured, provided that in the event that a partial payment is made by or on behalf of the insolvent insurer with respect to the legal liability of its insured, then the motor vehicle shall only be considered to be uninsured for the amount of the difference between the partial payment and the limits of the uninsured motorist coverage provided under the insured's motor vehicle insurance policy; or

No bond or deposit of cash or securities in lieu of bodily injury and property damage liability insurance.

A motor vehicle shall be deemed to be uninsured if the owner or operator of the motor vehicle is unknown. In those cases, recovery under the endorsement or provisions shall be subject to the conditions set forth in subsections (c) through (j) of this Code section, and, in order for the insured to recover under the endorsement where the owner or operator of any motor vehicle which causes bodily injury or property damage to the insured is unknown, actual physical

contact shall have occurred between the motor vehicle owned or operated by the unknown person and the person or property of the insured. Such physical contact shall not be required if the description by the claimant of how the occurrence occurred is corroborated by an eyewitness to the occurrence other than the claimant.

If the owner or operator of any motor vehicle which causes bodily injury or property damage to the insured is unknown, the insured, or someone on his behalf, or in the event of a death claim someone on behalf of the party having the claim, in order for the insured to recover under the endorsement, shall report the accident as required by Code Section 40-6- 273.

In cases where the owner or operator of any vehicle causing injury or damages is known, and either or both are named as defendants in any action for such injury or damages, and a reasonable belief exists that the vehicle is an uninsured motor vehicle under subparagraph (b)(1)(D) of this Code section, a copy of the action and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company were actually named as a party defendant. If facts arise after an action has been commenced which create a reasonable belief that a vehicle is an uninsured motor vehicle under subparagraph (b)(1)(D) of this Code section and no such reasonable belief existed prior to the commencement of the action against the defendant, and the complaint was timely served on the defendant, the insurance company issuing the policy shall be served within either the remainder of the time allowed for valid service on the defendant or 90 days after the date on which the party seeking relief discovered, or in the exercise of due diligence should have discovered, that the vehicle was uninsured or underinsured, whichever period is greater. The uninsured motorist carrier may conduct discovery as a matter of right for a period of not less than 120 days after service prior to any hearing on the merits of the action. If either the owner or operator of any vehicle causing injury or damages is unknown, an action may be instituted against the unknown defendant as "John Doe," and a copy of the action and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company were actually named as a party defendant; and the insurance company shall have the right to file pleadings and take other action allowable by law in the name of "John Doe" or itself.

In any case arising under this Code section where service upon an insurance company is prescribed, the clerk of the court in which the action is brought shall have such service accomplished by issuing a duplicate original copy for the sheriff or marshal to place his or her return of service in the same form and manner as prescribed by law for a party defendant.

The return of service upon the insurance company shall in no case appear upon the original pleadings in such case. In the case of a known owner or operator of such vehicle, either or both of whom are named as a defendant in such action, the insurance company issuing the policy shall have the right to file pleadings and take other action allowable by law in the name of either the known owner or operator or both or itself.

In cases where the owner or operator of a vehicle causing injury or damages is unknown and an action is instituted against the unknown defendant as "John Doe," the residence of such "John Doe" defendant shall be presumed to be in the county in which the accident causing injury or damages occurred, or in the county of residence of the plaintiff, at the election of the plaintiff in the action.

A motor vehicle shall not be deemed to be an uninsured motor vehicle within the meaning of this Code section when the owner or operator of such motor vehicle has deposited security, pursuant to Code Section 40-9-32, in the amounts specified in subparagraph (a)(1)(A) of this

Code section.

In cases where the owner or operator of any vehicle causing injury or damage is known and either or both are named as defendants in any action for such injury or damages but the person resides out of the state, has departed from the state, cannot after due diligence be found within the state, or conceals himself to avoid the service of summons, and this fact shall appear by affidavit to the satisfaction of the judge of the court, and it shall appear either by affidavit or by a verified complaint on file that a claim exists against the owner or driver in respect to whom service is to be made and that he is a necessary or proper party to the action, the judge may grant an order that the service be made on the owner or driver by the publication of summons. A copy of any action filed and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company issuing the policy were actually named as a party defendant. Subsection (d) of this Code section shall govern the rights of the insurance company, the duties of the clerk of court concerning duplicate original copies of the pleadings, and the return of service. Following service on the owner or driver by the publication of the summons as provided in this subsection and service as prescribed by law upon the insurance company issuing the policy, the plaintiff shall have a continuing duty to exercise diligence in attempting to locate the owner or driver against whom the claim exists, but such obligation of diligence shall not extend beyond a period of 12 months following service upon the owner or driver by publication of the summons.

However, regardless of such time limitations, should the plaintiff learn of the location of the owner or driver against whom the claim exists, the plaintiff shall exercise due diligence to effect service of process upon that owner or driver within a reasonable time period after receiving such information.

An insurer paying a claim under the endorsement or provisions required by subsection (a) of this Code section shall be subrogated to the rights of the insured to whom the claim was paid against the person causing such injury, death, or damage to the extent that payment was made, including the proceeds recoverable from the assets of the insolvent insurer, provided that the bringing of an action against the unknown owner or operator as "John Doe" or the conclusion of such an action shall not constitute a bar to the insured, if the identity of the owner or operator who caused the injury or damages complained of becomes known, bringing an action against the owner or operator theretofore proceeded against as "John Doe"; provided, further, that any recovery against such owner or operator shall be paid to the insurance company to the extent that the insurance company paid the named insured in the action brought against the owner or operator as "John Doe," except that the insurance company shall pay its proportionate part of any reasonable costs and expense incurred in connection therewith, including reasonable attorney's fees. Nothing in an endorsement or provisions made under this Code section nor any other provision of law shall operate to prevent the joining in an action against "John Doe" or the owner or operator of the motor vehicle causing such injury as a party defendant, and joinder is specifically authorized.

No endorsement or provisions shall contain a provision requiring arbitration of any claim arising under any endorsement or provisions, nor may anything be required of the insured, subject to the other provisions of the policy or contract, except the establishment of legal liability; nor shall the insured be restricted or prevented, in any manner, from employing legal counsel or instituting legal proceedings.

Before a motor vehicle shall be deemed to be uninsured because of the insolvency of an insurance company under division (b)(1)(D)(iv) of this Code section, an insurer under the uninsured motorists endorsement provisions of subsection (a) of this Code section must be

given notice within a reasonable time by its insured of the pendency of any legal proceeding against such insurance company of which he may have knowledge, and before the insured enters into any negotiation or arrangement with the insurance company, and before the insurer is prejudiced by any action or nonaction of the insured with respect to the determinations of the insolvency of the insurance company.

In addition to any offsets or reductions contained in the provisions of division (b)(1)(D)(ii) of this Code section, an endorsement or the provisions of the policy providing the coverage required by this Code section may contain provisions which exclude any liability of the insurer for injury to or destruction of property of the insured for which such insured has been compensated by other property or physical damage insurance and may contain provisions which exclude any liability of the insurer for personal or bodily injury or death for which the insured has been compensated pursuant to "medical payments coverage," as such term is defined in paragraph (1) of Code Section 33-34-2, or compensated pursuant to workers' compensation laws.

If the insurer shall refuse to pay any insured any loss covered by this Code section within 60 days after a demand has been made by the insured and a finding has been made that such refusal was made in bad faith, the insurer shall be liable to the insured in addition to any recovery under this Code section for not more than 25 percent of the recovery or $25,000.00, whichever is greater, and all reasonable attorney's fees for the prosecution of the case under this Code section. The question of bad faith, the amount of the penalty, if any, and the reasonable attorney's fees, if any, shall be determined in a separate action filed by the insured against the insurer after a judgment has been rendered against the uninsured motorist in the original tort action. The attorney's fees shall be fixed on the basis of competent expert evidence as to the reasonable value of the services, based on the time spent and legal and factual issues involved, in accordance with prevailing fees in the locality where the action is pending. The trial court shall have the discretion, if it finds such jury verdict fixing attorney's fees to be greatly excessive or inadequate, to review and amend such portion of the verdict fixing attorney's fees without the necessity of disapproving the entire verdict. The limitations contained in this subsection in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and his or her attorney for the services of the attorney in the action against the insurer.

Financial Responsibility Law

References: 40-9-1 through 12; 40-9-80 through 8; 33-34-4 **Summary**: These laws require drivers to demonstrate financial responsibility, typically through insurance, to cover damages or injuries they may cause in an accident.

Section 40-9-1 - Short title

This chapter shall be known and may be cited as the "Motor Vehicle Safety Responsibility Act."

Section 40-9-2 - Definitions

As used in this chapter, the term:

"Accident" means the collision of any motor vehicle with another vehicle or with any object or fixture, or involvement of a motor vehicle in any manner in which any person is killed or injured or in which damage to the property of any one person to an extent of $500.00 or more is sustained.

"Commissioner" means the commissioner of driver services.

"Department" means the Department of Driver Services.

"Operator" means every person who drives or is in actual physical control of a motor vehicle upon a highway or who is exercising control over or steering a vehicle being towed by a motor vehicle.

"Proof of financial responsibility" means proof of ability to respond in damages for liability on account of accidents occurring subsequent to the effective date of said proof in the amounts specified in subparagraph (a)(1)(A) of Code Section 33-7-11.

"Suspension of driver's license" means the temporary withdrawal by formal action of the department of a resident's license or nonresident's privilege to operate a motor vehicle on the public highways.

Section 40-9-3 - Administration of chapter; rules and regulations; hearings; appeals

The commissioner shall administer and enforce this chapter and is authorized to adopt and enforce rules and regulations necessary for its administration. The commissioner shall prescribe suitable forms requisite or deemed necessary for the purposes of this chapter.

The commissioner shall provide for hearings upon request of persons aggrieved by orders or acts of the commissioner under this chapter. Such hearings shall not be subject to the procedural provisions of Chapter 13 of Title 50, the "Georgia Administrative Procedure Act."

The commissioner is authorized to adopt and enforce rules and regulations necessary for the administration of such hearings, including but not limited to, hearings provided in Code Section 40-9-32. Except as provided in Code Section 40-9-32, a request for a hearing under this chapter shall not operate as a stay of any order or act of the commissioner.

The commissioner's decision as rendered at such hearing shall be final unless the aggrieved person shall desire an appeal, in which case he or she shall have the right to enter an appeal to the superior court of the county of his or her residence or the Superior Court of Fulton County by filing a complaint in the superior court, naming the commissioner as defendant, within 30 days from the date the commissioner enters his or her decision or order. The appellant shall not be required to post any bond nor pay the costs in advance. If the aggrieved person desires, the appeal may be heard by the judge at term or in chambers or before a jury at the first term. The hearing on the appeal shall be de novo. However, such appeal shall not act as a supersedeas of any order or acts of the commissioner, nor shall the appellant be allowed to operate or permit a motor vehicle to be operated in violation of any suspension or revocation by the commissioner while such appeal is pending.

Section 40-9-4 - Exceptions to application of chapter

This chapter shall not apply with respect to any motor vehicle owned by the United States, the State of Georgia, any political subdivision of this state, or any municipality therein, or any motor carrier required by any other law to file evidence of insurance or other surety. Code Sections 40-9-81, 40-9-7, 40-9-8, and 40-9-12 shall apply as to the operator of such motor vehicles.

All provisions of this chapter shall apply to the operator of such motor vehicles while on unofficial business.

Section 40-9-5 - Application of chapter to nonresidents, unlicensed drivers, and unregistered vehicles; accidents in other states

If the operator or the owner of a vehicle involved in an accident in this state has no license, such operator shall not be allowed a license until he or she has complied with the requirements of this chapter to the same extent that would be necessary if, at the time of the accident, he or she had

held a license in this state.

When a nonresident's operating privilege is suspended pursuant to Code Section 40-9-33 or 40-9-61, the department shall transmit a certified copy of the record of such action to the official in charge of the issuance of licenses and registration certificates in the state in which such nonresident resides, if the law of such other state provides for action in relation thereto similar to that provided for in subsection (c) of this Code section.

Upon receipt of a certification that the operating privilege of a resident of this state has been suspended in another state pursuant to a law providing for its suspension for failure to deposit security for the payment of judgments arising out of a motor vehicle accident, under circumstances which would require the department to suspend a nonresident's operating privilege had the accident occurred in this state, the department shall suspend the license of such resident. Such suspension shall continue until such resident furnishes evidence of his or her compliance with the laws of such other state relating to the showing of proof of financial responsibility or reinstatement of operating privilege.

Section 40-9-6 - [Repealed] Transfer of registration of vehicle after registration suspended

Repealed and reserved by 2005 Ga. Laws 68,§ 20-1, eff. 7/1/2005.

Section 40-9-7 - Surrender of license after suspension

Any person whose driver's license shall have been suspended under any provision of this chapter shall immediately return his or her license to the department. If any person shall fail to return such license to the department, the department shall direct any peace officer to secure possession thereof and to return it to the department.

Any person willfully failing to return his or her driver's license as required in subsection (a) of this Code section shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not to exceed $500.00 or by imprisonment for not more than 30 days, or by both such fine and imprisonment.

Section 40-9-8 - Operating vehicle during suspension of driver's license or operating privilege

Any person whose driver's license or nonresident's operating privilege has been suspended under this chapter and who, during such suspension, drives any motor vehicle upon any highway, except where permitted under this chapter, shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by imprisonment for not less than five days nor more than six months and there may be imposed in addition thereto a fine of not more than $500.00.

Section 40-9-9 - Reinstatement of driver's license; fee

Whenever a driver's license is suspended under any provisions of this chapter and the filing of proof of financial responsibility is made a prerequisite to reinstatement of such license, no such license shall be reinstated unless the driver or owner, in addition to complying with the other provisions of this chapter, pays to the department a fee of $25.00. Only one such fee shall be paid by any one person irrespective of the number of licenses to be reinstated. The fees paid pursuant to this Code section shall be expendable receipts to be used only by the department toward the cost of administration of this chapter.

Section 40-9-10 - Chapter supplemental

This chapter shall in no respect be considered as a repeal of the state motor vehicle laws but

shall be construed as supplemental thereto.

Section 40-9-11 - Chapter not to prevent other process

Nothing in this chapter shall be construed as preventing the plaintiff in any action at law from relying for relief upon the other processes provided by law.

Section 40-9-12 - Violations generally

Any person who shall violate any provision of this chapter for which no penalty is otherwise provided shall be guilty of a misdemeanor.

Section 40-9-80 - Methods of giving proof; duration

In all those situations under this chapter in which proof of financial responsibility for the future is required, such proof may be given by filing with the department:

A written certificate of any insurance carrier certifying that there is in effect a liability policy as to that vehicle meeting the requirements of subsections (a) and (b) of Code Section 40-9-37; or

A plan of self-insurance, accepted by the commissioner, as provided in Code Section 33-34-5.1.

Such proof must be maintained for a one-year period.

Section 40-9-81 - Proof required upon restoration of driver's license suspended for certain offenses

Whenever any person is convicted of any offense making mandatory the suspension of such person's driver's license, the department shall not restore the license to such person until permitted under the motor vehicle laws of this state, and not then unless and until such person shall give and thereafter maintain proof of financial responsibility for the future.

If such person does not have the required proof at any time during the one-year period following the date of restoration of his driver's license, the department shall immediately revoke the license.

Section 40-9-82 - Cancellation of insurance certificate

Any insurance company filing a certification with the department in order for the operator to show the proof required in this article shall not cancel such certification within 12 months from its effective date except for a subsequent conviction of any offense requiring the mandatory suspension of such operator's license, and the department shall be given at least 20 days' prior written notice of such cancellation. The commissioner may, in his discretion, permit the cancellation of such certificate for other cause made known to and approved by him.

Section 33-34-4 - Owner required to provide coverage

No owner of a motor vehicle required to be registered in this state or any other person, other than a self-insurer as defined in this chapter, shall operate or authorize any other person to operate the motor vehicle unless the owner has motor vehicle liability insurance equivalent to that required as evidence of security for bodily injury and property damage liability under Chapter 9 of Title 40, the "Motor Vehicle Safety Responsibility Act."

Georgia Automobile Insurance Plan/Assigned Risk References: 120-2-14.02 through .09; 40-9-100

Summary: This plan provides auto insurance for high-risk drivers who are unable to obtain coverage through the standard market.

Subject 120-2-14 GEORGIA AUTOMOBILE INSURANCE PLAN

Rule 120-2-14-.01 Authority

Rule 120-2-14-.02 Purpose

Rule 120-2-14-.03 Definitions

Rule 120-2-14-.04 Administration of the Plan

The Plan shall be administered by a Governing Committee and Manager. The Committee may consist of twelve (12) representatives. Eight

(8) representatives will be elected from among Plan subscriber companies, from each of the following classes of companies: two (2) from Georgia Association of Property and Casualty Insurance Companies, four (4) from American Property Casualty Insurers Association, and two (2) from Non- Affiliated Insurance Companies. Each of the eight (8) shall be submitted to the Commissioner for approval prior to election.

Two (2) representatives will be appointed by the Committee from the users of the Plan for a two (2) year term. These two (2) nominees selected by the Committee shall be approved by the Commissioner prior to being appointed. These two representatives will not have the right to vote in matters pertaining to the determination and fulfillment of quotas, Commercial Automobile Insurance Procedure participation, nor the cost to administer the Plan.

Two (2) representatives may be appointed at the discretion of the Commissioner from subscribers, users of the Plan, or the public. The users of the Plan and public representatives will not have the right to vote in matters pertaining to the determination and fulfillment of quotas, Commercial Automobile Insurance Procedure participation, nor the cost to administer the Plan.

For voting purposes, a quorum shall consist of a majority of the members currently serving on the Committee. If the Committee consists of an even number of members, however, a majority shall constitute one-half of those members but shall not be less than five members.

Each subscriber company serving on the Committee shall designate a representative to act on its behalf. This representative shall be either (1) a salaried employee or officer of the named subscriber company or (2) a salaried employee or officer of another subscriber company from a group of companies under the same management as the named subscriber company. A salaried employee or officer of the holding company of the named subscriber company may also be designated as the representative. No more than one (1) company in a group under the same management shall serve on the Committee at the same time. A company leaving its class of companies shall resign its seat at the next meeting of the Committee.

Biennially, on a date fixed by the Committee, such respective class of companies heretofore described shall elect its representatives to the Committee to serve for a period of two (2) years or until a successor is elected. Similarly, those elected representatives shall biennially, on a date fixed by the Committee, appoint the two representatives from among the users of the Plan.

A majority of such subscriber companies shall constitute a quorum and voting by proxy shall be permitted. A company may not appoint more than one (1) company in its class of companies to exercise its proxy.

The notice of each biennial meeting shall be accompanied by an agenda for such meeting. At the biennial meeting, a company may cast one

(1) vote for each vacant seat on the Committee for its class of companies and it may not cast two (2) votes for one seat. Forty-five (45) days notice of the biennial meeting shall be given in

writing to all companies which are subscribers to the Plan.

A vacancy on the Committee shall be filled by the respective organization (Georgia Association of Property and Casualty Insurance Companies or American Property Casualty Insurers Association) who shall appoint a successor to serve until the next biennial meeting. If a non-affiliated company vacancy occurs, a successor to serve until the next biennial meeting shall be elected by the non-affiliated companies. If a user of the Plan representative vacancy occurs, a successor to serve until the next biennial meeting shall be appointed by the committee.

A subscriber company seat not appointed by the Georgia Association of Property and Casualty Insurance Companies, Non-Affiliated Insurance Companies, or American Property Casualty Insurers by the appointment deadline shall be filled as determined by the Committee.

Rule 120-2-14-.05 Duties of Governing Committee

The Committee shall meet at least twice per year and as often as may be required to perform the duties of administration of the Plan. The Committee will be empowered and shall appoint a manager, budget expenses, levy assessments, disburse funds and perform all duties essential to the proper administration of the Plan.

Annually, the Manager shall prepare an operating budget in the prescribed manner for submission to the Committee. Such budget shall be approved by the Committee and furnished to the subscribers on request. Any expenditure in excess of or not included in the annual budget shall be approved by the Committee.

Upon request, the Committee will furnish to any subscriber a written annual report of operations of the Plan in such form and detail as the Committee may determine.

The Committee shall file with the Commissioner a manual including rates and manual rules in such detail as may be necessary for distribution and processing of automobile insurance applications received from applicants, the contents of such manual being known as the Plan.

The Committee shall file necessary and suitable amendments to the Plan as required for the continued effective operation of the Plan.

The Commissioner shall, within thirty (30) days of receipt of a filing as required in paragraphs (4) or (5) above, approved or disapproved such filing, provided, however, the Commissioner may extend by not more than thirty (30) days the period within which he may approve or disapprove the filing by giving written notice to the Committee of the extension before the expiration of the initial thirty-day period.

If the Committee fails to submit an acceptable Plan within thirty (30) days of the effective date of this Regulation, or if at any time fails to submit necessary or suitable amendments thereto, the Commissioner shall, after consultation with insurance companies authorized to issue automobile policies in this State and after notice and hearing, adopt and promulgate such reasonable Plan as is necessary or advisable to effectuate the provision of this Regulation.

Rule 120-2-14-.06 Plan Composition

Rule 120-2-14-.07 Participation in the Plan

Each subscriber shall pay a minimum annual fee of $25.00 and a Plan Fee of $25 and the basis used for distribution of risks under Distribution and Assignments of Applicants section of the approved Plan shall be used as the basis of apportionment of all expenses incurred in excess of the minimum fee except that credits allowed to reduce assignments shall not be considered in the apportionment of expenses.

The Committee may abate or defer in whole or in part the assignment of risks to a subscriber for good cause. When such action is contemplated, the Commissioner shall be promptly notified prior to the intended action being effective.

Each subscriber shall fully participate in the Plan, comply with paragraphs (1) and (2) above and comply with all rules and procedures of the Plan and guidelines of the Committee, as a condition of their authority to transact or continue to transact insurance in Georgia.

Rule 120-2-14-.08 Right to Appeal

The Committee may hear any appeal from an applicant, insured, producer or company on a matter pertaining to the proper administration of the Plan. Each notice of cancellation or denial of insurance under the provisions of the Plan shall contain or be accompanied by a statement that the insured or applicant has a right of appeal to the Committee. The action of the Committee may be appealed to the Commissioner, in accordance with O.C.G.A. Section 33-2-17.

The Plan shall promptly notify the company, the insured, or applicant, and the producer of record of the disposition of the appeal, which notification in the case of refusal to sustain a cancellation shall include notice that upon payment of the deposit premium to the company, a policy or binder will be issued.

An appeal shall not operate as a stay of cancellation. Provided, however, that if either the Committee or the Commissioner refuse to sustain the cancellation, the insurer which issued the policy or binder shall, within two (2) working days after receipt of the deposit premium, which must be received within thirty (30) days after determination of the appeal, issue a new policy or binder. Such policy shall be issued for a period of one (1) year from the date of issuance. The balance of the premium shall be payable as provided in the Plan rules.

The Commissioner shall be the final authority in all matters relating to the interpretation and enforcement of this Chapter, except insofar as his orders may be reversed or modified by the courts.

Rule 120-2-14-.09 Filing of Rates, Rating Systems, Rating Plans, Underwriting Rules and Policy Forms

Ga. Comp. R. & Regs. R. 120-2-14-.09

O.C.G.A. Secs. 33-2-9, 40-9-100.

Original Rule entitled "Eligibility" adopted. F. and eff. July 20, 1965. Repealed: New Rule of same title adopted. F. Mar. 4, 1968; eff. Mar. 24, 1968. Amended: F. Jan. 13, 1971; eff. Feb. 2, 1971. Amended: F. Feb. 24, 1975; eff. Mar. 16, 1975. Repealed: New Rule entitled "Filing of Rates, Rating Systems, Rating Plans, Underwriting Rules and Policy Forms" adopted. F. Oct. 5, 1984; eff. Nov. 1, 1984, as specified by the Agency.

Georgia Code § 40-9-100 - Assigned Risk Plan

After consultation with insurance companies authorized to issue automobile policies in this state, the Commissioner of Insurance shall approve a reasonable plan or plans for the equitable apportionment among such companies of applicants for motor vehicle liability policies and other automobile policies who are in good faith entitled to but are unable to procure such policies through ordinary methods. When any such plan has been approved, all such insurance companies shall subscribe thereto and participate therein.

Any applicant for a policy to be issued under any such plan, any person insured under any such

plan, and any insurance company affected may appeal to the Commissioner of Insurance from any ruling or decision of the manager or committee designated to operate such plan. Any person aggrieved by any order or act of the Commissioner of Insurance under this Code section may, within ten days after notice of such order or act, file a petition in the superior court of the county of his residence for a review thereof. The court will summarily hear his petition and may make any appropriate order or decree.

A person who has committed no traffic offenses for the prior three years and has had no claims based on fault against an insurer for the prior three years shall not be eligible for a policy to be issued under the plan created by this Code section unless such person's application or the subsequent investigation on the application discloses reasons for which the person would not be able to procure a policy through ordinary methods.

Reference Information

ABOUT THE GLB ACT

The Gramm-Leach-Bliley Act was enacted on November 12, 1999. In addition to reforming the financial services industry, the Act addressed concerns relating to consumer financial privacy. The Gramm-Leach-Bliley Act required the Federal Trade Commission (FTC) and other government agencies that regulate financial institutions to implement regulations to carry out the Act's financial privacy provisions (GLB Act). The regulations required all covered businesses to be in full compliance by July 1, 2001.

The FTC is responsible for enforcing its Privacy of Consumer Financial Information Rule (Privacy Rule). Anyone who uses this Guide should also review the Privacy Rule, found at 16 C.F.R. Part 313 (May 24, 2000).

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INTRODUCTION

The Gramm-Leach-Bliley Act seeks to protect consumer financial privacy. Its provisions limit when a "financial institution" may disclose a consumer's "nonpublic personal information" to nonaffiliated third parties. The law covers a broad range of financial institutions, including many companies not traditionally considered to be financial institutions because they engage in certain "financial activities."

Financial institutions must notify their customers about their information- sharing practices and tell consumers of their right to "opt-out" if they don't want their information shared with certain nonaffiliated third parties. In addition, any entity that receives consumer financial information from a financial institution may be restricted in its reuse and redisclosure of that information.

An overview of the privacy requirements of the GLB Act is available online. This guide provides more detailed information than in the overview, to help you comply with the Privacy Rule's requirements for protecting consumer financial information. It was written for businesses that provide financial products or services to individuals for personal, family, or household use.

WHO IS COVERED BY THE PRIVACY RULE

There are two ways that the Privacy Rule might cover you. First, if you are a "financial institution," you are covered. Parts I and II of this guide describe your obligations if you collect "nonpublic personal information" from your "customers" or "consumers" and define these terms. Second, if you receive "nonpublic personal information" from a financial institution with which you are not affiliated, you may be limited in your use of that information. Part III of this guide discusses your

obligations as a recipient of such protected information.

Are you a "financial institution"?

The Privacy Rule applies to businesses that are "significantly engaged" in "financial activities" as described in section 4(k) of the Bank Holding Company Act. Your activities determine whether you are a "financial institution" under the Privacy Rule.

According to the Bank Holding Company Act provision and regulations established by the Federal Reserve Board, "financial activities" include:

lending, exchanging, transferring, investing for others, or safeguarding money or securities. These activities cover services offered by lenders, check cashers, wire transfer services, and sellers of money orders.

providing financial, investment or economic advisory services. These activities cover services offered by credit counselors, financial planners, tax preparers, accountants, and investment advisors.

brokering loans.

servicing loans.

debt collecting.

providing real estate settlement services.

career counseling (of individuals seeking employment in the financial services industry).

These examples are taken from the section 4(k) provisions and regulations on financial activities.

Under the Privacy Rule, only an institution that is "significantly engaged" in financial activities is considered a financial institution. You need to take into account all the facts and circumstances of your financial activities to determine if you are "significantly engaged" in such activities. The FTC's "significantly engaged" standard is intended to exclude certain activities that might otherwise fall under the Privacy Rule. Two factors are particularly important in determining whether you are "significantly engaged" in a financial activity. First, is there a formal arrangement? A storeowner or bartender who "runs a tab" for customers is not considered to be significantly engaged in financial activities, but a retailer that offers credit directly to consumers by issuing its own credit card would be covered. Second, how often does the business engage in a financial activity? A retailer that lets some consumers make payments through an occasional lay-away plan is not "significantly engaged" in a financial activity. In contrast, a business that regularly wires money to and from consumers is significantly engaged in a financial activity.

Do you have consumers or customers?

If you are a financial institution, your obligations depend on whether your clients are "customers" or "consumers." In brief, the Privacy Rule requires you to give notice to all of your "customers" about your privacy practices, and, if you share their information in certain ways, to your "consumers" as well.

Under the Rule, a "consumer" is someone who obtains or has obtained a financial product or service from a financial institution that is to be used primarily for personal, family, or household purposes, or that person's legal representative. The term "consumer" does not apply to commercial clients, like sole proprietorships. Therefore, where your client is not an individual, or is an individual seeking your product or service for a business purpose, the Privacy Rule does not apply to you.

Examples of "consumer" relationships:

cashing a check with a check-cashing company

making a wire transfer

applying for a loan, whether or not you actually obtain the loan

"Customers" are a subclass of consumers who have a continuing relationship with a financial institution. It's the nature of the relationship - not how long it lasts - that defines your customers. Even if an individual repeatedly uses your services for unrelated transactions, she may not be your "customer." For example, if an individual uses the ATM at a bank where she does not have an account, those isolated transactions, no matter how frequent, do not make her that bank's customer. She would still be a "consumer" of that bank, however.

A former customer "has obtained" a financial product or service from a financial institution but no longer has a continuing relationship with it. For purposes of your obligations under the Privacy Rule, a former customer is considered to be a consumer.

Examples of "customer" relationships:

opening a credit card account with a financial institution

leasing an automobile from an auto dealer

using the services of a mortgage broker to secure financing

obtaining the services of a tax preparer or investment adviser

getting a loan from a mortgage lender or payday lender

A Word About Customer Relationships and Loans

A special rule defines the customer relationship when several financial institutions participate in a loan transaction. A financial institution establishes a customer relationship with an individual when it originates a loan. If the financial institution sells the loan but maintains the servicing rights, it continues to have a customer relationship with the individual. If the financial institution transfers the servicing rights but retains an ownership interest in the loan, the individual is a "consumer" of that institution and a "customer" of the institution with the servicing rights. If other institutions hold an ownership interest in the loan (but not the servicing rights), the individual is their consumer, too.

What information is covered?

The Privacy Rule protects a consumer's "nonpublic personal information" (NPI). NPI is any "personally identifiable financial information" that a financial institution collects about an individual in connection with providing a financial product or service, unless that information is otherwise "publicly available."

NPI is:

any information an individual gives you to get a financial product or service (for example, name, address, income, Social Security number, or other information on an application);

any information you get about an individual from a transaction involving your financial product(s) or service(s) (for example, the fact that an individual is your consumer or customer, account numbers, payment history, loan or deposit balances, and credit or debit card purchases); or

any information you get about an individual in connection with providing a financial product or

service (for example, information from court records or from a consumer report).

NPI does not include information that you have a reasonable basis to believe is lawfully made "publicly available." In other words, information is not NPI when you have taken steps to determine:

that the information is generally made lawfully available to the public; and

that the individual can direct that it not be made public and has not done so.

For example, while telephone numbers are listed in a public telephone directory, an individual can elect to have an unlisted number. In that case, her phone number would not be "publicly available."

Publicly Available Information Includes:

federal, state, or local government records made available to the public, such as the fact that an individual has a mortgage with a particular financial institution.

information that is in widely distributed media like telephone books, newspapers, and websites that are available to the general public on an unrestricted basis, even if the site requires a password or fee for access.

Information in a list form may be NPI, depending on how the list is derived. For example, a list is not NPI if it is drawn entirely from publicly available information, such as a list of a lender's mortgage customers in a jurisdiction that requires that information to be publicly recorded. Also, it is not NPI if the list is taken from information that isn't related to your financial activities, for example, a list of individuals who respond to a newspaper ad promoting a non-financial product you sell.

But a list derived even partially from NPI is still considered NPI. For example, a creditor's list of its borrowers' names and phone numbers is NPI even if the creditor has a reasonable basis to believe that those phone numbers are publicly available, because the existence of the customer relationships between the borrowers and the creditor is NPI.

Putting It All Together:

Examples of Nonpublic Personal Information (in list form)

list of a retailer's credit card customers

list of a payday lender's customers

list of auto loan customers merged with list of car magazine subscribers

Businesses That Receive NPI from Nonaffiliated Financial Institutions.

Even if your business is not a financial institution that has consumers or customers, the Privacy Rule may limit your use of NPI. Your ability to reuse and redisclose the information may be restricted if you receive NPI from a nonaffiliated financial institution. It depends on why you receive it (see "**LIMITS ON REUSE AND REDISCLOSURE OF NPI**").

YOUR OBLIGATIONS UNDER THE PRIVACY RULE

Privacy Notices.

Financial institutions must give their customers - and in some cases their consumers - a "clear and conspicuous" written notice describing their privacy policies and practices. When you provide the notice and what you say depend on what you do with the information.

Who Gets a Privacy Notice?

Customers

Whether or not you share customer NPI, you must give all your customers a privacy notice. You must provide an "initial notice" by the time the customer relationship is established.

If this would substantially delay the customer's transaction, you may provide the notice within a reasonable time after the customer relationship is established, but only if the customer agrees.

If you share NPI with nonaffiliated third parties outside of the exceptions described within (see "**Exceptions**"), you also must give your customers:

an "opt-out" notice explaining the individual's right to direct you not to share her NPI with a nonaffiliated third party;

a reasonable way to opt out; and

a reasonable amount of time to opt out before you disclose her NPI.

You must also give your customers an "annual notice" - a copy of your full privacy notice - for as long as the customer relationship lasts.

Consumers Who Are Not Customers

Before you share NPI with nonaffiliated third parties outside of the exceptions described within (see "**Exceptions**"), you must give your non- customer consumers a privacy notice, including an opt-out notice. If you don't share information with nonaffiliated third parties, or if you only share within the exceptions, you do not have to give a privacy notice to your consumers.

If you are required to provide a privacy notice to your consumers, you may choose to give them a "short-form notice" instead of a full privacy notice.

The short-form notice must:

- explain that your full privacy notice is available on request;
- describe a reasonable way consumers may get the full privacy notice; and
- include an opt-out notice.

The Contents of the Privacy Notice

Your notice must accurately describe how you collect, disclose, and protect NPI about consumers and customers, including former customers. Your notice must include, where it applies to you, the following information:

Categories of information collected. For example, nonpublic personal information obtained from an application or a third party such as a consumer reporting agency.

Categories of information disclosed. For example, information from an application, such as name, address, and phone number; Social Security number; account information; and account balances.

Categories of affiliates and nonaffiliated third parties to whom you disclose the information. For example, financial services providers, such as mortgage brokers and insurance companies; or non-financial companies, such as magazine publishers, retailers, direct marketers, and nonprofit organizations. You also may describe categories of other nonaffiliated parties to whom you may disclose NPI in the future.

Categories of information disclosed and to whom under the joint marketing/ service provider

exception in section 313.13 of the Privacy Rule (see "**Exceptions**").

If you are disclosing NPI to nonaffiliated third parties under the exceptions in sections 313.14 (exceptions for processing or administering a financial transaction) and 313.15 (exceptions, including fraud prevention or complying with federal or state law and others) of the Privacy Rule (see "**Exceptions**"), a statement that the disclosures are made "as permitted by law."

If you are disclosing NPI to nonaffiliated third parties, and that disclosure does not fall within any of the exceptions in sections 313.14 and 313.15, an explanation of consumers' and customers' right to opt out of these disclosures (see "**Opt-Out Notices**").

Any disclosures required by the Fair Credit Reporting Act (see "**Fair Credit Reporting Act**").

Your policies and practices with respect to protecting the confidentiality and security of NPI (see "**Safeguarding NPI**").

You only need to address those items listed above that apply to you. For example, if you don't share NPI with affiliates or nonaffiliated third parties except as permitted under sections 313.14 and 313.15, you can provide a simplified notice that: (1) describes your collection of NPI; (2) states that you only disclose NPI to nonaffiliated third parties "as permitted by law;" and (3) explains how you protect the confidentiality and security of NPI.

The Appearance of the Privacy Notice

The privacy notice must be "clear and conspicuous," whether it is on paper or on a website. It must be reasonably understandable, and designed to call attention to the nature and significance of the information.

The notice should use plain language, be easy to read, and be distinctive in appearance. A notice on a website should be placed on a page that consumers use often, or it should be hyperlinked directly from a page where transactions are conducted.

Safeguarding NPI

The FTC has issued a separate rule to address the requirements for safeguarding NPI. See 16 C.F.R. Part 314, 67 Fed. Reg. 36484 (May 23, 2002). You should consult the FTC's website for more information about this rule and further guidance for small businesses in implementing the Safeguards Rule requirements.

The Privacy Rule requires that your privacy notice provide an accurate description of your current policies and practices with respect to protecting the confidentiality and security of NPI. For example, if you restrict access to NPI to employees who need the information to provide products or services to your consumers or customers, say so.

Delivering Privacy Notices

You must deliver your privacy notices to each consumer or customer in writing, or, if the consumer or customer agrees, electronically. Your written notices may be delivered by mail or by hand. For individuals who conduct transactions with you electronically, you may post your privacy notice on your website and require them to acknowledge receiving the notice as a necessary part of obtaining a particular product or service. For annual notices, you may reasonably expect that your customers have received your notice if they use your website to access your financial products or services and agree to receive notices at your website, and you post your notice continuously in a clear and conspicuous manner on your website.

Notices given orally or posted in your office(s) don't comply with the rule. Opt-Out Notices

General Obligations

If you share their NPI with nonaffiliated third parties outside of three exceptions (see "**Exceptions**"), you must give your consumers and customers an "opt-out notice" that clearly and conspicuously describes their right to opt out of the information being shared. An opt-out notice must be delivered with a privacy notice, and it can be part of the privacy notice.

The opt-out notice must describe a "reasonable means" for consumers and customers to opt out. They must receive the notice and have a reasonable opportunity to opt out before you can disclose their NPI to these nonaffiliated third parties. Acceptable "reasonable means" to opt out include a toll-free telephone number or a detachable form with a check-off box and mailing information. Requiring the consumer or customer to write a letter as the only option is not a "reasonable means" to opt out.

Note: While the GLB Act does not require you to provide an opt-out notice if you only disclose NPI to affiliates, if you share certain information with your affiliates, you may have an obligation to provide an opt-out notice under the Fair Credit Reporting Act. That opt-out notice must be included in your GLB privacy notice (see "**Fair Credit Reporting Act**").

Exercising the Opt-Out Right

You must give consumers and customers a "reasonable opportunity" to exercise their right to opt out, for example, 30 days, after you send the initial notice either on- or off-line, before you can share their information with nonaffiliated third parties outside the exceptions. For an isolated consumer transaction, like buying a money order, you may require your consumers to make their opt-out decision before completing the transaction.

Consumers and customers who have the right to opt out may do so at any time. Once you receive an opt-out direction from your existing consumers or customers, you must comply with it as soon as is reasonably possible.

The Shelf Life of an Opt-Out Direction

An opt-out direction by a consumer or customer is effective - even after the customer relationship is terminated - until canceled in writing, or, if the consumer agrees, electronically. However, if a former customer establishes a new customer relationship with you and you are required to provide an opt-out notice, the customer must make a new opt-out direction that will apply only to the new relationship.

SUMMARY OF NOTICE REQUIREMENTS

Type of Notice	To Whom	When	Contents

Initial	Customers	Not later than when you establish the customer relationship, unless it would substantially delay the transaction and the customer	Description of information-collection and sharing practices, and opt-out notice (if you share NPI with nonaffiliated third parties outside of

Type of Notice	To Whom	When	Contents
		agrees	certain exceptions)
	Consumers who are not customers (including former customers)	Before you disclose their NPI to a nonaffiliated third party outside of certain exceptions	Full description of information-collection and sharing practices or "short-form" notice, along with opt-out notice
Annual	Customers	Delivery on a consistent basis at least once in any period of 12 consecutive months for the duration of the customer relationship	Description of information-collection and sharing practices, and opt-out notice (if you share NPI with nonaffiliated third parties outside of certain exceptions)

Exceptions

Exceptions to the Notice and Opt-Out Requirements

There are a number of exceptions to the notice and opt-out requirements. These exceptions are located in sections 313.14 ("section 14 exceptions") and 313.15 ("section 15 exceptions") of the Privacy Rule. If you share information only under these sets of exceptions, you don't need to give your consumers a privacy notice, but you will need to give your customers a simplified initial and, if applicable, an annual privacy notice. Customers and consumers have no right to opt out of these disclosures of NPI.

The section 14 exceptions apply to various types of information-sharing that are necessary for processing or administering a financial transaction requested or authorized by a consumer.

This includes, for example, disclosing NPI to service providers who help mail account statements and perform other administrative activities for a consumer's account. It also includes disclosures to and by creditors listed by a consumer on a credit application to perform a credit check.

The section 15 exceptions apply to certain types of information-sharing, including disclosures for purposes of preventing fraud, responding to judicial process or a subpoena, or complying with federal, state, or local laws. Examples of appropriate information disclosures under this exception include those made to technical service providers who maintain the security of your records; your attorneys or auditors; a purchaser of a portfolio of consumer loans you own; and a consumer reporting agency, consistent with the Fair Credit Reporting Act (see "**Exceptions**").

Exception to the Opt-Out Requirement: Service Providers and Joint Marketing

Another exception can be found in section 313.13 ("section 13 exception") of the Privacy Rule. If you share information under this exception, you must give your customers - and your consumers if you share their information - a privacy notice that describes this disclosure. However, your consumers and customers do not have a right to opt out of this information sharing.

The section 13 exception covers disclosures for certain service providers and for certain marketing activities. The section 13 exception covers disclosures to third party service providers whose services for you do not fall within the section 14 exceptions. For example, if you hire a nonaffiliated third party to provide services in connection with marketing your products or to market financial products jointly for you and another financial institution, or to do a general analysis of your customer transactions, your disclosure of NPI for these purposes does not fall under the section 14 exceptions. Therefore, you can use the section 13 exception for these types of service providers.

The section 13 exception also applies to marketing financial products or services offered through a "joint agreement" with one or more other financial institutions. The "joint agreement" requirement means that you have entered into a written contract with one or more financial institutions about your joint offering, endorsement, or sponsorship of a financial product or service.

This does not apply to any kind of joint marketing you do, but only joint marketing with other financial institutions and only the marketing of financial products or services.

To take advantage of the section 13 exception, you must enter into a contract with those nonaffiliated third parties with whom you share NPI. The agreement must guarantee the confidentiality of the information by prohibiting the third party or parties from using or disclosing the information for any purpose other than the one for which it was received. Contracts with nonaffiliated service providers that are effective before July 1, 2000 and don't have the required confidentiality agreement must be amended to include such a provision by July 1, 2002

LIMITS ON REUSE AND REDISCLOSURE OF NPI

General Obligations.

If you receive NPI from a nonaffiliated financial institution, your ability to reuse and redisclose that information is limited. The limits depend on how the information is disclosed to you. It does not matter whether or not you're a financial institution.

Restrictions on Reuse and Redisclosure if NPI is Received Under the Section 14 or 15 Exceptions

You may receive NPI from a nonaffiliated financial institution ("originating financial institution") under the section 14 or 15 exceptions. In these situations, you may only disclose and use the information in the ordinary course of business to carry out the purpose for which it was received. That purpose may include disclosures to other parties under the section 14 or 15 exceptions in order to carry out that activity, or as otherwise necessary, such as to respond to a subpoena. You may also disclose the information to your affiliates, who are limited in their reuse and redisclosure of the information in the same way as you are, and to affiliates of the originating financial institution.

Restrictions on Reuse and Redisclosure if NPI is Received Outside the Section 14 or 15 Exceptions

Alternatively, you may receive NPI from a nonaffiliated financial institution outside the section 14 or 15 exceptions.

For example, you may want to purchase a financial institution's customer list in order to market your own products to those individuals. In these cases, the originating financial institution may disclose NPI about those consumers or customers who were informed about this type of disclosure in the privacy notice, and who did not opt out after receiving notice and the opportunity to opt out.

In this situation, you may use the information internally for your own purposes. However, you may only redisclose the information consistent with the privacy policy of the originating financial institution. In other words, you step into the shoes of the originating financial institution and may disclose the same kinds of NPI to the same entities as the originating institution. For example, if the originating financial institution's privacy notice informed its consumers and customers that it would only share their NPI with "nonfinancial institutions, such as charitable organizations," you may redisclose the NPI to charitable institutions as well. However, because the originating institution does not disclose NPI to another financial institution, such as an insurance provider, you cannot because that type of company is not covered by the privacy policy.

You may also disclose the information to your affiliates, whose redisclosure is limited in the same way as you, and to affiliates of the originating financial institution.

DISCLOSURE OF ACCOUNT NUMBERS IS PROHIBITED

The GLB Act prohibits financial institutions from sharing account numbers or similar access numbers or codes for marketing purposes. This prohibition applies even when a consumer or customer has not opted-out of the disclosure of NPI concerning her account. The prohibition applies to disclosures of account numbers for an individual's credit card account, deposit account, or "transaction account" to any nonaffiliated third party to use in telemarketing, direct mail marketing, or other marketing through electronic mail to any consumer. A "transaction account" is any account to which a third party may initiate a charge. This provision does not prohibit the sharing of an encrypted account number, if the third party receiving the information has no way to decode it.

This prohibition applies to the complete marketing transaction, including posting a charge to an account. However, it does not apply when you disclose an account number to your agent or service provider just to market your own products or services, as long as the party receiving the information can't directly initiate charges to the account.

The exceptions in sections 313.14 and 313.15 of the Privacy Rule do not apply to the disclosure of account numbers for marketing purposes. For example, you may not obtain your customer's consent to disclose her account number for marketing purposes.

OTHER ISSUES

The Fair Credit Reporting Act

The Gramm-Leach-Bliley Act's notice and opt out provisions are in addition to the obligations imposed by the Fair Credit Reporting Act (FCRA). If the FCRA currently requires that you make clear and conspicuous disclosures to your consumers regarding your sharing of certain information (such as consumer report and application information) with your affiliates, you must continue to do so. The GLB Act requires these disclosures to be made as part of any privacy policy you give to your consumers or customers. See more information about the FCRA and how it applies to your information sharing practices.

Enforcement

The FTC, the federal banking agencies, (1) other federal regulatory authorities, (2) and state

insurance authorities enforce the GLB Act. Each agency has issued substantially similar rules implementing GLB's privacy provisions. The states are responsible for issuing regulations and enforcing the law with respect to insurance providers. The FTC has jurisdiction over any financial institution or other person not regulated by other government agencies.

The FTC may bring enforcement actions for violations of the Privacy Rule. The FTC can bring actions to enforce the Privacy Rule in federal district court, where it may seek the full scope of injunctive and ancillary equitable relief. The FTC also has authority under Section 5 of the FTC Act to examine privacy policies and practices for deception and unfairness.

Types Of Casualty Policies, Bonds, And Related Items

Personal Automobile

Liability Insurance

Definition: Liability insurance covers damages for bodily injury and property damage to others for which you are responsible.

Example: If you cause an accident, liability insurance will cover the medical expenses and repair costs for the other party.

What Is Liability Car Insurance?

Liability car insurance is the part of a car insurance policy that provides financial protection for a driver who harms someone else or their property while operating a vehicle. Car liability insurance only covers injuries or damages to third parties and their property—not to the driver or the driver’s property, which may be separately covered by other parts of their policy.

The two components of liability car insurance are bodily injury liability and property damage liability. Every state except New Hampshire requires drivers to have some degree of liability coverage

Key Takeaways

Liability car insurance provides financial protection for drivers who harm someone else or their property in a car accident.

Bodily injury liability helps cover medical expenses for those involved in the accident.

Property damage liability helps cover the costs of repairing the vehicles of other drivers involved in the accident.

Understanding Car Liability Insurance

Liability car insurance helps cover the cost of damage resulting from a car accident. In many states, if a driver is found to be at fault in the accident, their insurance company will pay the property and medical expenses of other parties involved in the accident up to the limits set by the policy.

In states with no-fault auto insurance, however, drivers involved in an accident must first file a claim with their own insurance companies regardless of who was at fault. In those states, drivers are typically required to purchase personal injury protection (PIP) coverage, which covers their accident-related medical expenses as well as those of their passengers.

Liability car insurance consists of two types of coverage: Bodily Injury

The bodily injury liability portion of a car insurance policy covers an at-fault driver, so they are not liable for others' emergency and ongoing medical expenses, loss of income, or funeral

costs. It also helps cover the policyholder's legal fees when the accident results in a lawsuit.

Property Damage

Property damage liability helps cover the costs of repairing or replacing the vehicles of other drivers involved in the accident. It also covers the damage done to other forms of property by the policyholder's vehicle, such as fencing, mailboxes or buildings.

Failing to obtain liability coverage could result in your license being suspended, fines or jail team for repeat offenses.

Liability Car Insurance Coverage Limits

Liability car insurance has dollar limits on each of its components, depending on the level of coverage you choose when you buy the policy. Those include:

Liability Limit for Property Damage

This limit is the maximum amount of coverage for damage done to property. Any costs that exceed the limit become the responsibility of the at-fault driver.

Liability Limit for Bodily Injury per Person

The per-person limit is the maximum amount that the insurance company will pay out for each individual who has been injured in an accident.

Liability Limit for Bodily Injury per Accident

The liability limit per accident is a financial cap for the total amount that the insurance company will pay for all of the individuals involved in an accident. In other words, the policy will cover medical expenses for those injured in an accident by the at-fault driver, but only up to an predetermined total. The at-fault driver would then be liable for any medical expenses above that limit.

Note

Bodily injury liability coverage can protect your home and other assets in the event that you're sued by a driver or passenger following an accident.

Requirements for Liability Car Insurance

Each state sets a minimum for how much liability coverage a motorist must carry. For example, a state might require all drivers to have liability insurance that covers $25,000 for injuries to one person, $50,000 for injuries to multiple people, $50,000 for death of one person, and $10,000 for property damage

Drivers can typically buy more liability insurance than their state's required minimums, and it's often smart to do so since medical bills can be very expensive.

If you have considerable assets to protect from a possible lawsuit, you may also want to consider buying an umbrella insurance policy, which can increase the liability coverage on both your auto and homeowners' insurance policies to $1 million or more.

Gap insurance is another type of coverage you may need if you drive an expensive vehicle that is likely to depreciate relatively quickly.

Example of Liability Car Insurance

Here is an example of how liability car insurance might work in a state without no-fault insurance. Let's say the motorist had the following liability car coverage with their insurance

company:

Bodily injury liability limit per person of $60,000

Bodily injury limit per accident of $150,000

The insured gets into an accident involving multiple people and is ruled at- fault for any damages.

Person A has medical costs totaling $30,000

Person B has medical costs totaling $40,000

Person C has medical costs totaling $50,000

The at-fault driver's liability would be covered in this instance because each person who was involved in the accident had medical expenses of under $60,000. Also, the total costs for everyone involved (except the at-fault driver) were $120,000, which is less than the per-accident bodily injury limit.

It's important to note that some policies will not cover any expenses beyond the per-accident limit even if the per-person limits have not been exceeded. Using the example above, let's say each person had medical expenses of $55,000. Although those individual costs all fall within the per-person limit of $60,000, the total cost of $165,000 is over the per-accident limit of

$150,000. As a result, the at-fault driver would be liable for the additional $15,000.

While states set mandatory minimums for car insurance liability coverage, buying more than the minimum is often a smart move.

Liability vs. Full-Coverage Automobile Insurance

In addition to the liability coverage your state requires, insurers offer coverage known as collision and comprehensive insurance. A policy with all three—liability, collision, and comprehensive—is sometimes referred to as providing "full coverage." A full-coverage policy will cost you more than a liability-only policy, but it will also protect you against more financial risks.

Unlike property damage liability insurance, which covers another person's car if you damage it, collision and comprehensive insurance cover your own car.

Collision insurance helps pay to repair or replace your car if it's damaged in an accident involving another vehicle or an object, such as a tree or a wall

Comprehensive insurance helps pay to replace or repair your vehicle if it's stolen or damaged in an incident that's not a collision. Comprehensive typically covers damage from fire, vandalism, or falling objects, such as a large tree limb or hail.

These two types of insurance are optional for vehicles that are owned free and clear. But if the vehicle is financed, the lender may require that you have them. The lender wants to protect the vehicle’s value since it serves as collateral for the loan. Even if you aren't required to have collision or comprehensive insurance, you may want to buy it unless you could easily pay a major repair bill out of pocket.

Bodily Injury

Definition: Covers medical expenses, lost wages, and legal fees for injuries you cause to others in an accident.

Example: If you injure another driver in an accident, bodily injury liability will cover their medical bills.

Property Damage

Definition: Covers the cost of damages you cause to another person's property, such as their car or a fence.

Example: If you hit another car, property damage liability will pay for the repairs.

Split Limits

Definition: Specifies different maximum payout amounts for different types of claims (e.g., bodily injury per person, bodily injury per accident, property damage per accident).

Example: A policy with split limits of 100/300/50 means $100,000 for bodily injury per person, $300,000 total for bodily injury per accident, and $50,000 for property damage.

Combined Single Limit

Definition: Provides a single maximum payout amount for all types of claims combined (bodily injury and property damage).

Example: A combined single limit policy of $300,000 would cover any combination of bodily injury and property damage up to that amount.

What Are Combined Single Limits?

Combined single limits refer to a provision of an insurance policy that limits the coverage for all components of a claim (bodily injury per person, bodily injury per accident, and property damage) to a single dollar amount.

That is, a combined single limit liability policy has a maximum dollar amount that covers any combination of injuries or property damage in an incident. A combined single limit can also be used to cover bodily injury claims for more than one person in an incident.

For example, the policy might state that the insurer will pay up to "x" dollars for a single claim. This applies whether the claim relates to one person's injuries, whether there are three injured parties, or whether there is property damage in addition to bodily injury.

The combined single limit maxes out at the stated dollar amount no matter the claim categories.

Combined single limit policies are helpful because they allow insurance companies to apply the maximum amount of coverage where it's needed.

Key Takeaways

Combined single limits are a provision of an insurance policy that limits the coverage for all components of a claim to a single dollar amount.

A combined single limit policy has a maximum dollar amount that covers any combination of injuries or property damage in an incident.

Combined single limit policies tend to have higher premiums than split limit policies because they offer broader coverage.

How Combined Single Limits Work

Combined single limit liability policies–also called single limit policies–are frequently used in automobile insurance. The combined single limit refers to a maximum amount of money that's

paid out for claims that involve all aspects of bodily injury and property damage. The limit would cover all people involved in the accident or the claim (other than the insured). The maximum amount of coverage would be split between those injured.

Combined Single Limit vs. Split Limit

The opposite of a combined single limit is a split limit, which states different maximum dollar amounts that the insurer will pay for different components of a claim.

A split limit policy coverage breaks up the payout into three areas of coverage:

- Bodily injury per person
- Bodily injury per incident
- Property damage

For example, a policy with a combined single limit might pay a maximum of

$300,000 per incident. On the other hand, a policy with split limits might pay $100,000 per person per incident for bodily injury, with a maximum payout of $300,000 per incident.

If one person seeks $250,000 in damages for their injuries, the combined single limit policy will cover the entire amount of $250,000. However, the maximum payout under the split limit policy would be $100,000. The only way the split limit policy would pay $300,000 is if three different people each had $100,000 in claims.

Since they offer broader financial coverage, combined single limit policies tend to have higher premiums. Another way to obtain broader coverage than a split limit policy offers is to purchase a personal liability umbrella policy. This type of policy picks up where your automobile and homeowners insurance leaves off.

Regardless of which type of limit your insurance policy uses, an umbrella policy can ensure that you’re fully covered if you’re held liable for a very expensive accident. For example, if you have a combined single limit policy or a split limit policy that maxes out at $300,000, but you’re being sued for $1 million, your umbrella policy could provide the additional financial protection you'd need.

Combined single limit policies can benefit those with a lot of assets to protect. However, for those with few assets, such policies might not be worth the cost.

Advantages and Disadvantages of Combined Single Limits Advantages

Combined single limit policies have several distinct advantages. They can eliminate the need for additional coverage because the single, dedicated amount for accident claims enables an insurance carrier to divide it as needed.

Plus, people with significant assets, such as a home can feel confident that the financial protection they need will be available in a single limit policy because there is no limit on what's payable per claim component.

For example, if an accident results in a large amount of property damage but very little bodily injury, the bulk of the coverage can be focused on the property damage claim.

Disadvantages

One big disadvantage of combined single limit coverage is that the premiums generally are more expensive than for a split limit policy due to the greater, more flexible coverage.

Another is that claims resolutions can take longer. That's because, when there's a single amount of money that payouts are drawn from, insurance companies will often need all parties to submit their claims before settling any single one.

What Does Combined Single Limits Mean in Insurance?

It refers to liability coverage that has a single coverage amount that will be applied as needed to bodily injuries and property damage.

What Is the Difference Between Combined Single Limits and Split Limits?

Where a combined single limit policy has one coverage amount for the distinct liability categories of bodily injury and property damage, a split limit policy has set amounts for each category.

Is a Combined Single Limit Policy Better?

That depends. The flexibility of applying a single coverage amount as it's needed is a great benefit. Coverage in a split limit policy is firmly set per bodily injury and damage categories. But a combined single limit policy is more expensive than a split limit policy. So, you'd have to decide if its advantages are worth the added cost.

The Bottom Line

A combined single limit insurance policy is one where the coverage is a single dollar amount that covers both bodily injury and property damage claims as needed. It's different from a split limit insurance policy, which sets a specific dollar limit for each component.

Combined single limit coverage is more expensive than split limit coverage due to the broader financial protection it affords buyers. This added cost can be justified for those with significant assets to safeguard in case of lawsuits.

Medical Payments

Definition: Covers medical expenses for you and your passengers, regardless of who is at fault in an accident.

Example: If you and your passenger are injured in an accident, medical payments coverage will pay for your medical bills.

Medical Payments (MedPay) Coverage Key Takeaways

Medical Payments (MedPay) insurance helps cover medical expenses for you and your passengers after a car accident.

It is an optional form of coverage in most of the states where it’s available.

Regardless of who is at fault in an accident, Medical Payments Coverage, commonly referred to as MedPay, can assist in paying medical costs for you and your passengers.

What Is MedPay Coverage?

MedPay coverage is designed to cover medical expenses related to a car accident, up to your policy limit. It pays regardless of who is at fault in the accident, providing coverage for you and your passengers. This allows you access to financial assistance for necessary medical treatment without having to wait for fault determinations.

MedPay has a broad scope of coverage. It typically covers hospital visits, doctor's fees, surgery, X-rays, and ambulance fees, and sometimes even extends to funeral expenses. It can also help

pay out-of-pocket costs like deductibles.

MedPay is versatile. It can cover policyholders in their own cars and as passengers in other vehicles. It can also provide coverage if you are struck by a car as pedestrians.

Is MedPay Coverage Required?

MedPay Coverage is generally an optional addition to auto insurance policies, but it's mandatory in a few states: New Hampshire, Pennsylvania, and Maine. In these states, auto insurance policies include MedPay as a required component, ensuring drivers have some coverage for medical expenses following a car accident, regardless of who is at fault.

State insurance regulations can change, so it's always a good idea to verify current requirements with your state's insurance department or consult an insurance provider for the most up-to-date information.

How Does MedPay Differ from Personal Injury Protection (PIP)?

MedPay and Personal Injury Protection (PIP) are auto insurance coverages that deal with medical expenses after a car accident but differ in scope and coverage. MedPay typically covers only medical and funeral expenses resulting from auto accidents. It does not cover lost wages or other non- medical costs.

On the other hand, PIP, which is often mandatory in "no-fault" states, is more comprehensive. It covers medical expenses, lost wages, and sometimes non-medical household expenses like childcare costs.

Similar to MedPay, PIP offers coverage regardless of who is at fault in an accident, but with a broader range of protections.

How Is MedPay Different from Bodily Injury Liability?

MedPay and bodily injury liability are different types of auto insurance with different purposes. MedPay covers the medical expenses of the policyholder and their passengers, regardless of who is at fault in an accident.

In contrast, bodily injury liability is a core component of liability insurance. It can cover the medical expenses, pain and suffering, and lost wages of other parties injured in an accident where the policyholder is at fault. It does not cover the policyholder's or the policyholder's passengers' injuries.

How Much MedPay Coverage Do I Need?

Determining the right amount of MedPay coverage depends on individual circumstances and your state's requirements. In states where MedPay is mandatory, there's a minimum required amount – for instance, New Hampshire requires motorists to carry at least $1,000 of Medical Payments Coverage – but you may opt for higher coverage based on personal needs. Generally, you may want to consider your health insurance, potential out- of-pocket medical expenses, and the likelihood of significant medical costs in an accident. Balancing these factors with the cost of increased premiums can help you choose appropriate MedPay coverage.

Other Types of Car Insurance Coverage

The car insurance landscape is diverse, and there are many different types of coverage tailored to different risks and requirements. Depending on the state, some of these coverages are mandatory, while others are optional, offering drivers a chance to customize their policies based on individual needs and circumstances.

Bodily injury liability

This coverage is essential for protecting the policyholder against claims arising from injuries to others in an accident where the policyholder is at fault. It can cover medical bills, lost wages, and legal fees.

Property damage liability

This coverage is for damage caused by the policyholder to someone else's property, usually another vehicle, but it can also include buildings, fences, or other types of property.

Uninsured/ underinsured motorist

This protects you if you're in an accident with a driver without insurance or one with inadequate coverage. It can cover medical expenses and sometimes even property damage.

Collision

This coverage pays for damage to the policyholder's car resulting from a collision with another vehicle or stationary object, or the upset (overturning) of your vehicle, regardless of who is at fault.

Comprehensive

Sometimes called "other than collision" coverage, this insurance protects against damage from non-collision incidents, like theft, vandalism, natural disasters, and damage caused by an animal.

Personal injury protection

Mandatory in some states, particularly those with no-fault laws, PIP covers medical expenses, lost wages, and some other non-medical costs for the policyholder, regardless of fault.

Do I need MedPay if I already have health insurance?

Even if you already have health insurance, MedPay can be beneficial in covering out-of-pocket expenses like deductibles and copays. It activates regardless of who is at fault in an accident. MedPay can also be a financial cushion for those with high-deductible health plans, providing coverage up to its limit for costs that could otherwise come out of pocket. For individuals without health insurance, MedPay may be even more crucial. It offers help with medical expenses resulting from a car accident, reducing the risk of financial strain.

Physical Damage

Definition: Covers damage to your own vehicle.

Collision

Definition: Covers damage to your vehicle resulting from a collision with another vehicle or object.

Example: If you hit a tree, collision coverage will pay for the repairs to your car.

Other Than Collision (Comprehensive)

Definition: Covers damage to your vehicle from non-collision events such as theft, fire, or natural disasters.

Example: If your car is stolen, comprehensive coverage will pay for the loss.

When Do I Need Physical Damage Coverage for My Car?

Physical damage coverage is a category of auto insurance that covers damage to your vehicle from car accidents and other sudden, unexpected causes. It is not required by law, but you may need physical damage coverage if you are financing or leasing your car.

Keep reading for more information about what physical damage insurance covers and whether it's necessary for your vehicle.

Key Takeaways

Physical damage insurance, which consists of collision and comprehensive coverage, pays to repair your car after a crash or unexpected peril.

Collision insurance covers damage to your car after an accident even if you were at fault, while comprehensive insurance covers fire, hail, theft, vandalism and more.

Most physical damage coverage policies pay out total losses at your car's actual cash value after you pay your deductible.

Physical damage insurance is not required by law in any state, but it may be required by your lender or lessor if you are financing or leasing your car.

Americans paid $544.99 on average for collision and comprehensive coverage in 2020.

What Types of Physical Damage Coverage Are There?

There are two main types of physical damage coverage you can purchase to protect your vehicle: collision coverage and comprehensive coverage.

Collision

Collision insurance can pay for repairs to your vehicle after a car accident regardless of who was at fault. It is the only type of auto insurance that covers your car repairs after a collision you were responsible for. For example, it could help you pay to fix your front bumper after you miss a stop sign and crash into another car.

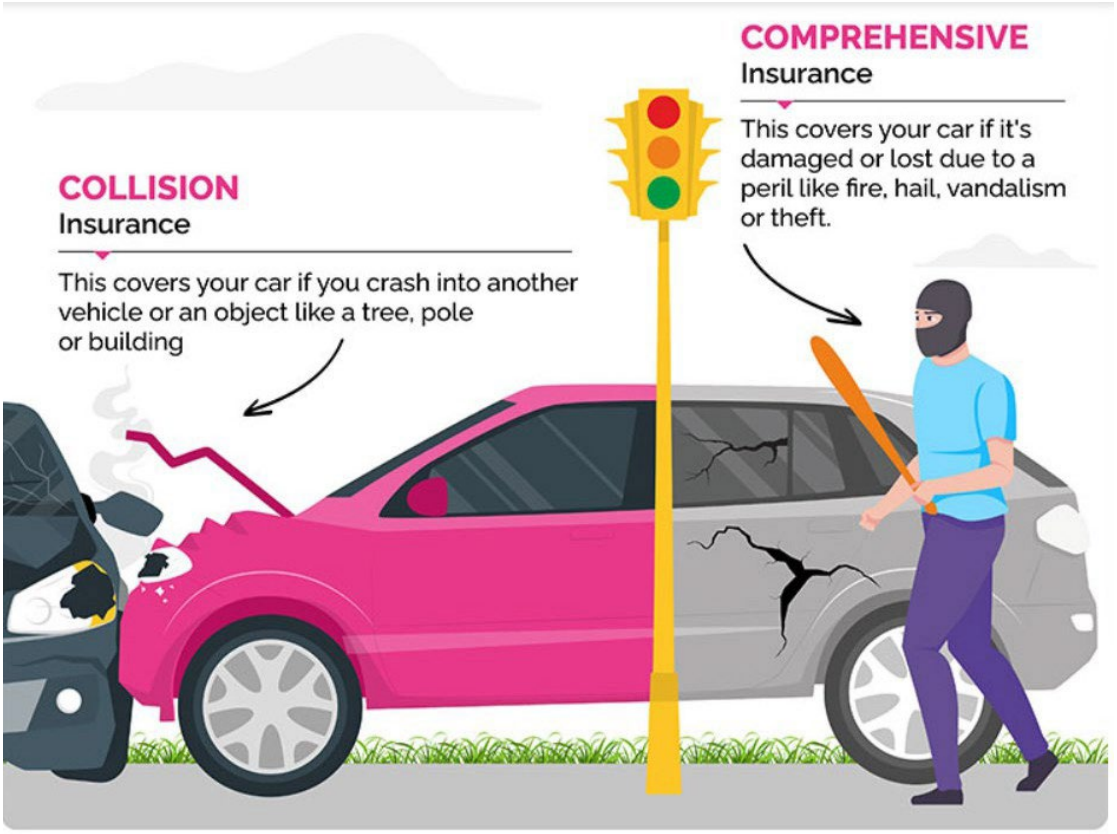
You could also file a claim on your collision insurance after an accident caused by another driver.

However, this could cause your rates to go up unless you live in California or Oklahoma, where it is illegal for insurance companies to raise your rates after an accident you weren't responsible for. As a result, it may be better to file a claim on the other person's liability insurance if they were the at- fault driver.

Comprehensive

Comprehensive insurance covers sudden and unexpected damage to your vehicle from a source outside of your control.

Sometimes known as "other than collision" coverage, it accounts for most forms of non-collision damage to your car. These can range from natural disasters like wildfires and hailstorms to human actions like theft and vandalism.



A subset of comprehensive coverage known as **fire and theft with combined additional coverage (CAC)** is reserved for large commercial trucks and only covers damage from perils specifically named in the policy.

How Does Physical Damage Insurance Work?

You must regularly pay your premiums to maintain your comprehensive and collision coverage. Whenever you get into an accident, **you will have to pay your deductible before your insurer will chip in**. For example, if you have a $500 deductible and you cause $2,000 worth of damage to your car in an accident, then your insurance company would contribute $1,500 for your repairs.

In the event of a total loss, most policies would reimburse you at your car's actual cash value (ACV), which is the value of your car when taking depreciation factors like age or wear and tear into account. However, you could receive enough money to buy a new vehicle after a total loss if you purchase an optional car insurance add-on called new car replacement insurance.

What Does Physical Damage Insurance Cover?

Physical damage insurance covers a wide range of collision and non- collision damages. Below are some examples of situations that would be covered by your collision insurance:

Collision with another vehicle: You fail to check your mirrors and crash into another car while trying to switch lanes on the highway.

Collision with an object: You doze off at the wheel and crash into a tree.

Single-car rollover: You spin out after driving too fast on an icy road and flip your car over while trying to regain control of the vehicle.

Meanwhile, the following perils would be covered by your comprehensive insurance:

Fire: Your propane grill explodes in your garage and sets your car on fire.

Hailstorm: A chunk of hail creates a large dent in the roof of your car.

Windstorm: A tornado blows a tree branch through your windshield.

Theft: An intruder damages your car's electrical system while attempting to hotwire it.

Vandalism: Your ex keys the side of your car and punctures your tires after your breakup.

Civil disturbance: Your car gets flipped over by a group of rioters.

Falling objects: A meteor falls on your car and destroys your engine.

Collision with an animal: Your front bumper and headlights are damaged after a deer runs into your vehicle.

What Isn't Covered?

Physical damage coverage typically won't pay for anything that is already covered by another insurance type or that isn't covered by car insurance in general. Below are some circumstances that aren't covered by physical damage auto insurance and whether they are covered by another type of insurance.

Description	Example	Covered By?
Someone else's medical bills, lost wages and/or funeral expenses after an accident you were responsible for	You strike a pedestrian while texting and driving	Bodily injury liability coverage
Your medical bills and/or funeral expenses	You get whiplash and need to see a doctor after rear-ending another vehicle	Medical payments coverage or personal injury protection (also covers lost wages)

Someone else's car or property repairs after an accident you were responsible for	You speed out of your driveway to try to get your kids to school on time and run over your neighbor's mailbox in the process	Property damage liability coverage
Medical expenses and/or repairs after an accident caused by an uninsured	Someone without insurance hits your car in a parking lot then drives away	Uninsured motorist coverage

Description	Example	Covered By?
driver		
	Medical expenses and/or repairs that exceed the at-fault driver's policy limits	

You rack up
$30,000 in hospital bills after an accident caused by someone with
$25,000 worth of bodily injury liability coverage

Underinsured motorist coverage

Outstanding loans on a lost vehicle

Your insurance company pays you
$25,000 after your car is totaled but you still owe
$30,000 to your lender

Gap insurance

Rental costs

Your car is destroyed in a fire and you need to rent a car while you wait for an insurance payout that you can use to buy a new vehicle

Rental reimbursement coverage

Damage from a mechanical or electrical breakdown

Your brakes stop working due to an internal failure rather than an

Mechanical breakdown insurance

Description	Example	Covered By?
	external cause	
Tows, jumpstarts, fuel delivery, locksmithing services and/or emergency tire replacements	You run over a nail on the way to work and need to get your tire replaced	Roadside assistance plan
Belongings stolen from your vehicle	Someone steals your car while your laptop is inside	Homeowners or renters' insurance
Routine repairs and maintenance	You take your car to a local auto shop for its routine inspection	Not covered by insurance

Do I Need Physical Damage Insurance?

Physical damage insurance is not required by law in any state, although **your lender may require you to purchase collision and**

comprehensive coverage before approving you for a car loan. However, if you have finished paying off your car or can afford to pay for your car upfront, you are not obligated to buy physical damage coverage.

Nevertheless, physical damage coverage is generally a wise investment since it steps in when there isn't another at-fault driver whose insurance can cover your repair bills.

But, as your car gets older and loses value, physical damage insurance may eventually cease to be economical. **It will likely be worth dropping collision and comprehensive coverage once their premiums cost more than 10 times the value of your car.**

How Much Does Physical Damage Insurance Cost?

The average American in 2020 paid **$370.73 a year for collision coverage** and **$174.26 a year for comprehensive coverage**. Meanwhile, the average annual cost for a full coverage policy with both physical damage insurance and liability insurance was $1,176.18.

Your premium can vary depending on factors like the age and model of your car, your driving record and claims history, where you live and, in some cases, your credit score.

How To File a Physical Damage Claim

If your car is damaged by an accident or unexpected peril, you can take the following steps to file a car insurance claim through your physical damage coverage:

Call 911 to report any injuries and have an officer write up a police report.

Take photos of the damage and any other relevant features of the accident scene.

Contact your insurance provider and submit relevant photos and documents.

Check your deductible and use Kelley Blue Book to estimate your car's ACV so you can get an idea of how much money you can expect from your insurance company.

Get an estimate from a repair shop.

Accept your insurance payout and get your car fixed.

How Does Physical Damage Insurance Work?

You must regularly pay your premiums to maintain your comprehensive and collision coverage. Whenever you get into an accident, you will have to pay your deductible before your insurer will chip in. For example, if you have a $500 deductible and you cause $2,000 worth of damage to your car in an accident, then your insurance company would contribute $1,500 for your repairs.

In the event of a total loss, most policies would reimburse you at your car's actual cash value (ACV), which is the value of your car when taking depreciation factors like age or wear and tear into account. However, you could receive enough money to buy a new vehicle after a total loss if you purchase an optional car insurance add-on called new car replacement insurance.

What Does Physical Damage Insurance Cover?

Physical damage insurance covers a wide range of collision and non- collision damages. Below are some examples of situations that would be covered by your collision insurance:

Collision with another vehicle: You fail to check your mirrors and crash into another car while trying to switch lanes on the highway.

Collision with an object: You doze off at the wheel and crash into a tree.

Single-car rollover: You spin out after driving too fast on an icy road and flip your car over while trying to regain control of the vehicle.

Meanwhile, the following perils would be covered by your comprehensive insurance:

Fire: Your propane grill explodes in your garage and sets your car on fire.

Hailstorm: A chunk of hail creates a large dent in the roof of your car.

Windstorm: A tornado blows a tree branch through your windshield.

Theft: An intruder damages your car's electrical system while attempting to hotwire it.

Vandalism: Your ex keys the side of your car and punctures your tires after your breakup.

Civil disturbance: Your car gets flipped over by a group of rioters.

Falling objects: A meteor falls on your car and destroys your engine.

Collision with an animal: Your front bumper and headlights are damaged after a deer runs into your vehicle.

Is physical damage coverage required?

Physical damage coverage is not required by law in any state, but it may be required by your lender or lessor if you are financing or leasing your car.

Do fire and theft fall under physical damage?

Fire and theft should be covered by your comprehensive insurance, which is a type of physical damage coverage.

Who needs physical damage insurance?

You need physical damage insurance if you are financing or leasing your car and you may want to keep it as long as your car is worth more than 10 times the cost of your premiums.

Specified Perils

Definition: Covers damage from specific risks explicitly named in the policy, such as fire or theft.

Example: If your car is damaged by a hailstorm, specified perils coverage will pay for the repairs.

So, what are “specified perils” in insurance? Here, we’re explaining what this insurance term means in simple language. That way you’ll be prepared the next time you’re shopping for an insurance policy.

So, what are specified perils, and how does it affect your coverage?

Specified perils in insurance explained

In insurance, a peril is essentially a risk that can be covered.

This includes things like fire, water and glass breakage. With specified perils, you’re only covered for the risks that are explicitly listed in your policy.

We get into the details of exactly what these risks are below.

What are specified perils in insurance?

In insurance, “specified perils” refers to a type of coverage in property insurance policies.

In short, specified perils coverage provides protection for specifically listed risks otherwise known as “perils” that are explicitly mentioned in the policy.

These perils typically include common threats like fire, lightning, theft, vandalism, and certain natural disasters like windstorms or hail.

Specified Perils vs. Comprehensive Coverage

Unlike comprehensive or “all-perils” insurance”, which covers a broader range of risks (unless excluded), specified perils only cover the perils explicitly named in the policy.

It's often chosen by policyholders who want more affordable coverage, as it can be less expensive than comprehensive coverage policies.

As a policyholder, make sure that you understand the list of specified perils in your insurance policy to ensure you have adequate coverage for your circumstances.

If a peril isn't listed, it won't be covered unless specifically added through endorsements.

What are the different types of perils?

Perils, which pose threats to your home or property, fall into different categories.

In general, here are the four different categories of insurance perils:

Weather-related perils: This includes damage caused by hail, wind, or lighting.

Natural disaster related perils: Common natural disaster perils include flooding, storms, tornadoes, etc.

Perils related to human causes: This includes events like theft, vandalism, and more.

Other perils: War, explosion, nuclear disaster, etc.

If you're unsure about whether a specific peril is listed on your policy, make sure that you ask your insurance broker.

What is not covered in specified perils?

Remember: If you have specified perils coverage, any perils that aren't explicitly listed in your policy are not covered.

The exception is if you add it through endorsements or choose a more comprehensive policy.

Common exclusions in specified perils insurance can include:

Floods and overland water damage:

These are typically not covered and require a separate policy or endorsement.

Earthquakes:

Earthquake coverage is generally excluded but can be added as an endorsement.

Damage from freezing pipes: Unless it's explicitly listed, this type of damage might not be covered.

Gradual wear and tear:

Specified perils policies don't cover damage caused by aging or deterioration. In fact, no insurance policy does.

Business-related losses:

If you run a business from your home, your business-related losses may not be covered.

Intentional damage:

Deliberate acts of damage or vandalism are not covered.

When it comes to your own policy, make sure to review its exclusions to understand what's not covered so that you don't experience any surprises in the event of a claim.

If there are specific risks that you want protection for, be sure to discuss them with your insurer

to determine if additional coverage is needed.

That way, you can address any gaps in your insurance.

All Perils Insurance Coverage: This type of coverage offers broader protection. It typically covers all risks and perils unless they are explicitly excluded in the policy. Because it provides a more comprehensive coverage for a wide range of incidents, it tends to be more expensive. You can read our blog explaining all perils insurance coverage in-depth here.

Specified Perils Insurance Coverage: With specified perils coverage, you get protection only for the specific risks or perils that are explicitly listed in your policy. These perils usually include common threats like fire, theft, vandalism, and certain natural disasters. Specified perils insurance is more limited in scope but can be more affordable since it covers a narrower range of risks.

Some common examples of covered perils in property insurance include:

Fire and Smoke: Most policies cover damage caused by fires, including smoke damage.

Theft: Theft coverage protects against the loss of your belongings due to theft or burglary.

Vandalism: Damages caused by acts of vandalism, such as graffiti or property destruction, are typically covered.

Wind and Hail: Damage from windstorms and hail, which are common in many parts of Canada, is usually included.

Lightning Strikes: Coverage extends to damage caused by lightning strikes, which can lead to fires or electrical system damage.

Explosions: Damage caused by explosions, such as gas explosions or other accidental blasts, is typically covered.

Falling Objects: If a tree limb, satellite dish, or another object falls and damages your property, it's often covered.

Snow accumulation: Damage from the weight of ice or snow accumulation, like a collapsed roof, is generally included.

Aircraft or Vehicle Impact: Damage resulting from aircraft or vehicle collisions with your property is typically covered.

Remember: It's important to carefully review your policy to understand which perils you're covered for.

You can also consider adding endorsements or additional coverage if you live in an area prone to specific risks not included in a standard policy.

Wrap-up

So, let's recap.

Perils are covered risks on your insurance policy.

Specified perils is a coverage option where particular risks are only covered if it's explicitly included on your insurance policy.

So, unlike all perils coverage, you're only covered for select perils.

You can work with your broker to decide which coverages are appropriate for your situation, and

whether you'll need any additional endorsements.

Uninsured Motorists

Definition: Covers your medical expenses and property damage if you are hit by a driver who does not have insurance.

Example: If an uninsured driver hits your car, this coverage will pay for your medical bills and car repairs.

Uninsured motorist insurance spares you from shelling out your own money for injuries or property damage from crashes you didn't cause. Some states require this coverage, although it is available to most U.S. drivers. And it usually doesn't cost much to add to your auto policy.

Here's what to know about uninsured motorist coverage. How uninsured motorist coverage works

An uninsured motorist is a person who has no liability car insurance. When you're in an accident and the other driver is at fault, their insurance is supposed to pay for your car repairs and medical costs for you and your passengers. If the other driver doesn't have insurance and can't pay, you can wind up paying the bill.

Uninsured motorist coverage is designed to close the gap between your costs and the other driver's ability to pay.

Uninsured vs. underinsured motorist coverage

Uninsured motorist coverage is often sold with underinsured motorist coverage. They both pay for the same types of expenses after an accident, with one key difference: Uninsured motorist coverage pays after a crash with an at-fault driver who has no insurance, while underinsured motorist coverage is reserved for accidents with an at-fault driver who has some insurance, but not enough to cover all costs.

What does uninsured motorist coverage pay for?

Uninsured motorist coverage pays for injuries or damages that you, family members in your household or passengers in your car suffer after an accident with an at-fault driver who has no insurance.

There are two types of uninsured motorist coverage:

Uninsured motorist bodily injury, or UMBI, pays for medical bills, pain and suffering, lost wages if you can't work after an accident and funeral expenses after a crash with an at-fault driver who doesn't have car insurance. It may also cover you if an uninsured driver hits you as a pedestrian or while riding your bike.

Uninsured motorist property damage, or UMPD, pays for damage to your car or property after an accident with an at-fault driver with no car insurance. If you live in a state that requires a deductible for this type of coverage, you are responsible for paying a certain amount of a claim and then your insurance will cover the rest (up to your policy limit).

If you're looking for even more protection, you may want to consider full coverage insurance. However, there's no such thing as a "full coverage policy" — that's just the word used to describe a policy that includes comprehensive and collision insurance as well as your state's minimum car insurance requirements.

Which states require uninsured motorist coverage?

Drivers in 20 states and Washington, D.C., are required to carry uninsured motorist coverage. Car insurance isn't mandatory in Virginia, but if drivers do purchase a policy, it must include both uninsured motorist bodily injury and property damage coverage. Some states require you to reject the coverage in writing if you don't want it.

Even if uninsured motorist coverage isn't required where you live, you may still want the extra security it provides. Roughly 13% of drivers nationwide

— or about 1 in 8 — drove uninsured in 2019, according to a 2021 study by the Insurance Research Council,

Uninsured/Underinsured Motorist Coverage Requirements Alabama

Coverage is optional but may not be offered by all insurers.

Alaska

Coverage is optional but may not be offered by all insurers.

Arizona

Coverage is optional but may not be offered by all insurers.

Arkansas

Coverage is optional but may not be offered by all insurers.

California

Coverage is optional but may not be offered by all insurers.

Colorado

Coverage is optional but may not be offered by all insurers.

Connecticut

UMBI & UIMBI required.

$25,000 per person/$50,000 per accident

Delaware

Coverage is optional but may not be offered by all insurers.

Florida

Coverage is optional but may not be offered by all insurers.

Georgia

Coverage is optional but may not be offered by all insurers.

Hawaii

Coverage is optional but may not be offered by all insurers.

Idaho

Coverage is optional but may not be offered by all insurers.

Illinois

UMBI required.

$25,000 per person/$50,000 per accident

Indiana

Coverage is optional but may not be offered by all insurers.

Iowa

Coverage is optional but may not be offered by all insurers.

Kansas

UMBI & UIMBI required.

$25,000 per person/$50,000 per accident

Kentucky

Coverage is optional but may not be offered by all insurers.

Louisiana

Coverage is optional but may not be offered by all insurers.

Maine

UMBI & UIMBI required.

$50,000 per person/$100,000 per accident

Maryland

UMBI/UIMBI required: $30,000 per person/$60,000 per accident UMPD/UIMPD required: $15,000 per accident

Massachusetts

UMBI required.

$20,000 per person/$40,000 per accident

Michigan

Coverage is optional but may not be offered by all insurers.

Minnesota

UMBI/UIMBI required.

$25,000 per person/$50,000 per accident

Mississippi

Coverage is optional but may not be offered by all insurers.

Missouri

UMBI required.

$25,000 per person/$50,000 per accident

Montana

Coverage is optional but may not be offered by all insurers.

Nebraska

UMBI/UIMBI required.

$25,000 per person/$50,000 per accident

Nevada

Coverage is optional but may not be offered by all insurers.

New Hampshire

UMBI/UIMBI required: $25,000 per person/$50,000 per accident UMPD/UIMPD required: $25,000 per accident

New Jersey

Coverage is optional but may not be offered by all insurers.

New Mexico

Coverage is optional but may not be offered by all insurers.

New York

UMBI required.

$25,000 per person/$50,000 per accident

North Carolina

UMBI required: $30,000 per person/$60,000 per accident UMPD required: $25,000 per accident

North Dakota

UMBI/UIMBI required.

$25,000 per person/$50,000 per accident

Ohio

Coverage is optional but may not be offered by all insurers.

Oklahoma

Coverage is optional but may not be offered by all insurers.

Oregon

UMBI required.

$25,000 per person/$50,000 per accident

Pennsylvania

Coverage is optional but may not be offered by all insurers.

Rhode Island

Coverage is optional but may not be offered by all insurers.

South Carolina

UMBI required: $25,000 per person/$50,000 per accident UMPD required: $25,000 per accident

South Dakota

UMBI/UIMBI required.

$25,000 per person/$50,000 per accident

Tennessee

Coverage is optional but may not be offered by all insurers.

Texas

Coverage is optional but may not be offered by all insurers.

Utah

Coverage is optional but may not be offered by all insurers.

Vermont

UMBI/UIMBI required: $50,000 per person/$100,000 per accident UMPD/UIMPD required: $10,000 per accident

Virginia

Car insurance in Virginia is not required, but if purchased, uninsured motorist coverage is required at these minimum limits.

UMBI/UIMBI required: $25,000 per person/$50,000 per accident UMPD/UIMPD required: $20,000 per accident

Washington

Coverage is optional but may not be offered by all insurers.

Washington, D.C.

UMBI required: $25,000 per person/$50,000 per accident UMPD required: $5,000 per accident

West Virginia

UMBI required: $25,000 per person/$50,000 per accident UMPD required: $25,000 per accident

Wisconsin

UMBI required.

$25,000 per person/$50,000 per accident

Wyoming

Coverage is optional but may not be offered by all insurers.

The cost of uninsured motorist coverage

Compared with other types of coverage in an auto policy, prices for uninsured motorist insurance are relatively low. However, uninsured motorist coverage can be more expensive in states with a higher number of uninsured drivers.

Since liability insurance is meant to protect your assets should you cause a wreck, you would want the same financial assurance if someone else caused the wreck. For that reason, it’s standard to purchase uninsured motorist coverage in at least the same amounts as your liability limits.

Policy limits are the maximum amounts your insurance will pay per claim. If you choose an amount of uninsured motorist coverage that matches the limit of your liability insurance, you should have the same amount of coverage whether the accident is caused by you or by an uninsured driver.

The more assets you have in your name and the more liability insurance you purchase, the higher your costs for uninsured motorist coverage are likely to be.

Still, uninsured motorist insurance is cheaper than liability coverage when purchased in the same amounts — generally less than half the cost.

'Stacked' uninsured motorist coverage

Depending on your state and insurance company, you may have the option to “stack” your uninsured motorist coverage. For an extra cost, you can combine uninsured motorist bodily injury limits for multiple vehicles — either under one policy or across several policies in your name — to increase the overall coverage in an accident.

Say you own two cars insured under one policy, each with $50,000 of uninsured motorist bodily injury coverage. If you choose to stack the coverage, any injury expenses from an accident with an at-fault uninsured driver would be covered up to $100,000, the total stacked policy limit.

Underinsured Motorists

Definition: Covers your medical expenses and property damage if you are hit by a driver who does not have enough insurance to cover all your costs.

Example: If an underinsured driver causes an accident and their insurance is insufficient, this coverage will pay the remaining costs.

Who is an Insured

Definition: Specifies who is covered under the policy, typically including the policyholder, family members, and anyone driving the car with permission.

Example: If your friend borrows your car and gets into an accident, they would be covered under your policy.

Who is Insured?

Car insurance policies have 2 general classes of insured people, named insureds and everyone else. The name insured is named at the top of the document and is self-explanatory. Of course, they have coverage.

Spouses are normally covered as insureds. What if they are separated? There is a case that says if separated but under the same roof, then the coverage still applies. Filing for divorce or court-ordered separation will terminate the insurance coverage.

Other resident relatives living under the same roof are also afforded liability insurance under the policy. This applies when they are driving the insured vehicle or a non-owned vehicle (one borrowed from a friend or a rental). If driving a car they own or another resident relative owns, then the omnibus clause coverage does not extend over them.

Types of Auto

Owned

Definition: Vehicles owned by the policyholder.

Example: Your personal car.

Non-owned

Definition: Vehicles not owned by the policyholder but used with permission.

Example: A rental car.

Hired

Definition: Vehicles rented or leased by the policyholder.

Example: A car rented for a business trip.

Temporary Substitute

Definition: A vehicle used temporarily while the insured vehicle is being repaired.

Example: A loaner car from the repair shop.

Substitute Vehicles: Are You Covered?

Automobile insurance policies cover the vehicles you own but there may be times when you need to drive a different vehicle temporarily. A "substitute vehicle" is any vehicle that you do not own but you drive when you are unable to operate your insured vehicle. Some examples of a substitute vehicle include:

A rental vehicle while on vacation. Even though your personal auto policy will provide liability and physical damage coverage as carried on your vehicle, personal policies do not typically provide coverage for the diminished value for damaged rental vehicles or for the loss of use of the rental vehicle while it is being repaired. These items will be your responsibility.

A loaner vehicle provided by a dealer while they are servicing your vehicle. Policy language varies depending on the insurance carrier. Not all carriers consider a vehicle loaned to you by the dealer as a "non-owned" vehicle since the dealership is engaged in the business of selling, repairing or servicing motor vehicles.

A borrowed vehicle. Coverage on a borrowed vehicle from a family member or friend will primarily be provided by the borrowed vehicle's policy with your personal auto policy being secondary in the event of inadequate limits.

Even though most personal auto policies will typically provide limited coverage for a temporary substitute vehicle (30 days or less), specific coverages and limitations can vary. In this case, surprises are not a good thing! Therefore, it is recommended that you check with your independent agent to be sure there is coverage for your specific situation.

Newly Acquired Autos

Definition: New vehicles acquired by the policyholder that are automatically covered for a limited time.

Example: A new car you just bought.

Any auto purchased after the effective date, but before the expiration date of an auto policy is considered "newly acquired." Most companies provide automatic coverage as long as they are notified 7 to 30 days of the purchase.

Transportation Expense and Rental Reimbursement Expense

Definition: Covers the cost of renting a car while your vehicle is being repaired after a covered

loss.

Example: If your car is in the shop after an accident, this coverage will pay for a rental car.

What is extended transportation expenses coverage?

Extended transportation expenses coverage – sometimes referred to as rental reimbursement coverage – is an optional coverage that can pay for a rental car, other forms of transportation or other transportation expenses if your car is damaged in a covered accident. This coverage typically pays for these expenses while your vehicle is not safely drivable or is at a repair facility.

What does extended transportation expenses insurance cover?

Extended transportation expenses coverage can cover the cost of public transportation, such as bus, train or car service. This coverage applies to insured vehicles that are involved in a covered comprehensive or collision loss. It can also apply when non-owned vehicles you drive are involved in a covered loss, such as a rental car you drive while on vacation.

Do I need rental reimbursement coverage?

You should discuss your individual situation with your independent agent. Generally, if you require a car daily or don't have another alternative for transportation, you may want to consider purchasing this coverage.

How much does rental reimbursement cover?

In most states, the lowest limits provided would be up to $30 per day, for a maximum of $900, and the highest limits provided would be up to $100 per day, for a maximum of $3,000. If the rental car you choose costs more or you need to use it longer, you will be responsible for the difference.

If you have auto insurance and use a preferred rental car company, they can bill the insurance company directly for your rental car. Make sure to ask the rental car company if direct billing is available. You may be required to provide a form of payment to meet the rental company's security deposit requirement.

You have a right to use any rental provider or location you choose. If you choose another rental provider, you may have to pay the cost up front, and your carrier will reimburse you up to the limits of your rental reimbursement coverage.

What is not covered by transportation expenses insurance?

Rental reimbursement coverage does not cover the costs of gas, mileage or any security deposit required by the rental car company.

Rental reimbursement coverage also does not include the cost of any additional coverage offered by the rental company. Typically, rental car companies will ask if you want additional coverage to cover the rental car. If you have comprehensive or collision coverage on your insurance policy, you may not need the additional coverage from the rental car company. It is up to you to decide if you wish to get the additional coverage.

Do I have to pay my deductible for extended transportation expenses coverage?

There is no deductible applicable to extended transportation expenses coverage.

Exclusions

Definition: Specific situations or conditions that are not covered by the policy.

Example: Damage caused by intentional acts or using the vehicle for illegal activities.

Auto Insurance Exclusion

An auto insurance exclusion is a provision that is written into your car insurance policy that excludes coverage for a particular driver or situation.

It's important to know what an exclusion is and which exclusions might be written into your policy so you make sure you have the coverage you need if and when an incident occurs.

What Is an Exclusion?

An exclusion is anything that is specifically not covered by your car insurance policy. They are listed in your policy in the Exclusions section.

Types of car insurance exclusions include, but are not limited to:

Individual drivers. For example, you and your insurer may agree to exclude a high-risk driver in your household to save you money on your premium. (See "Named Driver Exclusions" below.)

Certain types of damages or injuries. For example, a liability property damage policy will exclude damages you cause to your own vehicle in an accident, since liability policies only cover damages and injuries to other drivers in accidents you cause.

Weather events or natural disasters. For example, if you hold only collision insurance, don't expect your damages to be paid for after a hurricane. This will be excluded; you need comprehensive coverage to pay for these types of incidents.

Continue reading for more information on the types of exclusions you might see in your car insurance policy.

Named Driver Exclusions

Named driver exclusions occur when your policy specifically does not cover a specific, named individual.

In general, most car insurance policies automatically cover every licensed driver living in your household; unfortunately, if you live with someone whose driving record is riddled with tickets or accidents, you can end up paying higher rates for their past mistakes.

However, in most cases you can choose to exclude her from your policy. It is important to understand, though, that this means she CANNOT drive your car. If she does, she will not be covered, meaning if she gets into an accident you're on the hook for paying costs out of pocket.

Also, you might simply live with someone who you know will never need to drive your vehicle. If this is true, you can also elect to exclude him. Always consider this option carefully, however. You may not think this driver will never need your car, but emergencies do arise and he might need to drive your vehicle at some point.

NOTE: Some states and companies don't allow you to exclude drivers on your policy. Speak with your auto insurance agent if you are considering excluding a driver.

Other Types of Policy Exclusions

Policy exclusions aren't limited to specific drivers in your household. Commonly, insurance

policies will exclude coverage for:

Livery conveyance. Some insurance companies will not cover you if you are involved in an auto accident while using your car or truck to carry passengers or materials for compensation.

Fraud. Intentional damage is typically excluded in any car insurance policy.

Certain vehicles. Some vehicles, such as those you regularly use but aren't listed on your policy, may be excluded.

Vehicle types, such as motorcycles, will likely not be covered under a car insurance policy. You'll need a motorcycle endorsement for that.

Certain uses of your vehicle. For example, drag racing is another auto exclusion that your car insurance company might write into your policy.

In this case, your car insurance company would not cover you if you are injured while drag racing.

Catastrophes. Damages caused by specific catastrophic events, such as nuclear exposure, will generally be excluded under your policy.

Custom equipment. Without a custom parts and equipment endorsement, your custom equipment is unlikely to be covered.

The above is not an exhaustive list of exclusions. Speak with your agent to learn what is and is not covered in your car insurance policy.

Understanding Your Car Insurance Policy

All exclusions are written in your insurance policy, even if they're not that easy to find.

Always read the fine print of your policy so you know exactly what is excluded. If you don't know what's excluded, you may end up thinking you've got coverage and finding out when it comes time to pay for damages that you don't.

Umbrella/Excess Liability

Definition: Provides additional liability beyond the limits of your underlying policies, such as auto or homeowners insurance.

Example: If you are sued for damages that exceed your auto insurance liability limits, an umbrella policy will cover the excess amount.

What is Umbrella Insurance and Do I Need It?

If you have a fair amount of retirement assets saved up (like a lot of folks out there), the answer may well be yes. Here's why and what to expect.

Homeowners insurance, car insurance, health insurance, life and disability insurance … if you already have all these policies in place as part of a strategic protection plan for yourself and your assets, you might find it hard to believe that there could possibly be yet another type of insurance that you need.

But the reality is, the more complex your financial situation gets — and the more your net worth grows — the more pressing it becomes to consider umbrella insurance on top of your current policies.

Here's why (and when) you should think about an umbrella insurance policy, and what you need to know before applying for coverage.

What Is Umbrella Insurance?

Umbrella insurance (also known as excess liability insurance) is a type of coverage designed to cover potential gaps left by other insurance policies you may already have in place. If you needed to pay for expenses relating to claims that exceeded the coverage provided by existing insurance, umbrella insurance could help cover those costs.

A good way to think about umbrella insurance is as an extra layer of protection in order to help you avoid financial hardship should a major accident or unexpected event happen. It's like a fail-safe to completely protect your personal savings and assets.

What Umbrella Insurance Covers and How It Works

If you're sued for damages that exceed the liability limits of your car insurance, homeowners' insurance or other coverages, an umbrella policy would step in to help you pay what you owe.

While this might sound like something that would never happen, it's more common than you might think. We can take a look at a real-life example to see how an umbrella insurance policy works to protect you in the case of an unforeseen circumstance.

You might have heard of Georgia's infamous 2014 Snowmageddon event, where forecasts that called for unusually significant snowfall midweek were largely ignored. When snow began to fall fast and thick around lunchtime, there was a mass exodus of folks trying to commute home from work and school. Combine Atlanta's existing traffic and congestion problems with untreated roads, bad winter weather and residents with no experience navigating such conditions, and it quickly turned chaotic on the roads.

Now, imagine you were one of those drivers that day. As you tried to get home, your car spun out of control on a snowy hill. You totaled the car next to you — and even worse, several people were badly injured.

The totaled car cost $80,000 to replace. Treatment of injuries cost a combined $800,000. In this situation, you'd be responsible for $880,000 in damages … and you carry $300,000 in liability coverage through your car insurance.

The remaining $580,000 would have to come out of your pocket. That's a major hit — and a good reason to think carefully about purchasing umbrella coverage, which in this case would have stepped in and paid what your car insurance did not cover.

How Much Umbrella Insurance Costs

Coverage limits on umbrella policies typically start at $1 million, and in most cases, go as high as $5 million. Basic policies at the lower end of that coverage range can cost between $150 to $300 per year.

Keep in mind that your umbrella insurance may only cover a claim if you maintain the minimum coverage amounts required by your other insurance companies (for things like home and auto). If the umbrella insurance provider feels you are not maintaining appropriate levels of insurance on your other policies, they may not extend a policy offer to you.

This rule protects the insurance carrier from individuals who are trying to carry minimum state liability coverages (to drive down their auto and home policy premiums) and supplement those coverages with the extremely low cost of an umbrella policy.

Who Needs Umbrella Insurance Coverage, and How Much Is Enough

Umbrella insurance is an optional insurance policy, not required by most state laws. Even so, there are specific reasons you might want to seriously consider obtaining umbrella coverage:

You have significant savings or assets to safeguard.

Protecting your assets is just as important as growing them, especially when umbrella insurance costs relatively little to carry.

Visitors could injure themselves on property you own.

Do you own, rent or borrow things that can lead to injury? If you have a pool, tree house, ATV, trampoline or dog, you could be liable for major expenses if somebody gets hurt on your property.

You're responsible for others — and thus at risk of being sued.

If you're a landlord, a kids' sports coach or someone who serves on the board of a nonprofit, your responsibilities might put you in a vulnerable position. Umbrella coverage can help offset any major expenses you might incur through this work.

You walk on the wild side or travel abroad.

Do you participate in sports where you can easily injure others, such as skiing, surfing, hunting or — my personal favorite — mixed martial arts? If you were to accidentally cause someone else injury and they sued, umbrella insurance would likely cover you. Your policy can also protect against liability claims against you while traveling outside of the United States.

You're kind of a big deal.

If you need to protect yourself from defamation lawsuits, like libel and slander, consider umbrella coverage. Those proceedings can get costly quickly.

Once you know you need a policy, determining the right amount is fairly simple: Subtract your respective liability coverage limit from all assets at risk, including home equity, personal property, investments and savings.

A negative result indicates a gap in coverage, which umbrella insurance can help fill. And finding funds to pay for the policy can be simple, too.

Consider increasing the annual deductibles on your auto and home policies from $500 and $1,000 to something more in line with the $1,500 to $2,500 range (ensure you have adequate cash reserves). This change should help reduce the cost of monthly premiums and give you the cash flow savings needed to afford this new policy without any additional outlay.

Example: Fire is a peril that can cause damage to property.

E. Hazard

Definition: A condition that increases the likelihood of a loss occurring.

Example: Leaving candles unattended is a fire hazard.

F. Loss

Direct

Direct Definition: Physical damage or destruction of the insured property by a covered peril.

Example: Fire damage to a house.

Indirect

Indirect Definition: Consequential losses that occur as a result of a direct loss.

Example: Loss of rental income due to fire damage to a rental property.

G. Proximate Cause

Definition: The primary cause of a loss in a chain of events.

Example: A windstorm causes a tree to fall on a house, making the windstorm the proximate cause of the damage.

H. Deductible

Definition: The amount the policyholder must pay out-of-pocket before the insurance company pays a claim.

Example: An auto insurance policy with a $500 deductible means the policyholder pays the first $500 of a repair bill.

I. Indemnity

Definition: The principle of restoring the insured to the financial position they were in before the loss.

Example: Paying to repair a damaged car to its pre-accident condition.

J. Actual Cash Value (ACV)

Definition: The replacement cost of damaged property minus depreciation.

Example: A five-year-old laptop with an ACV of $200, considering its depreciation from its original cost of $1,000.

K. Replacement Cost

Definition: The cost to replace damaged property with new property of similar kind and quality without deducting for depreciation.

Example: Replacing a destroyed roof at today's prices, regardless of its age.

L. Limits of Liability

Definition: The maximum amount an insurance company will pay for a covered loss.

Example: An auto liability policy with a limit of $100,000 per accident.

M. Coinsurance

Definition: A clause requiring the policyholder to carry insurance equal to a certain percentage of the property's value to receive full reimbursement on a claim.

Example: A commercial property with a $1 million value requiring 80% coinsurance must be insured for at least $800,000.

N. Pair and Set Clause

Definition: A provision stating that if part of a pair or set is damaged, the insurance company will pay to repair or replace the entire pair or set or the difference in value.

Example: One of a pair of diamond earrings is lost, and the insurance covers the value of the lost earring or the pair's total value.

O. Extensions of Coverage

Definition: Additional coverages provided under a standard insurance policy.

Example: A homeowners policy extending coverage to personal property while traveling.

P. Additional Coverages

Definition: Specific coverages added to the policy, often for an additional premium.

Example: Adding coverage for valuable jewelry to a homeowners insurance policy.

Q. Accident

Definition: An unforeseen and unintentional event causing loss or damage.

Example: A car collision resulting in vehicle damage and injuries.

R. Occurrence

Definition: An event, including continuous or repeated exposure to conditions, that results in injury or damage during the policy period.

Example: Continuous water leakage causing mold over time.

S. Vacancy and Unoccupancy

Definition: Vacancy refers to a property being empty of both people and personal property, while unoccupancy means the absence of people but not personal property.

Example: A vacant house is completely empty, whereas an unoccupied house still has furniture but no residents for a period.

T. Right of Salvage

Definition: The insurer's right to take possession of damaged property after compensating the insured for a total loss.

Example: The insurance company takes possession of a totaled car after paying the claim.

U. Abandonment

Definition: Prohibits the insured from abandoning damaged property to the insurer and demanding payment for a total loss.

Example: A policyholder cannot abandon a damaged car to the insurer and claim a total loss payment.

V. Liability

Definition: Legal responsibility for causing harm or damage to another person or property.

Example: A homeowner's liability for injuries sustained by a guest slipping on their icy sidewalk.

W. Negligence

Definition: Failure to take reasonable care to avoid causing injury or loss to another person.

Example: A driver running a red light and causing an accident.

X. Theft

Definition: The unlawful taking of someone's property with the intent to deprive them of it permanently.

Example: A thief steals a bicycle from a garage.

Y. Burglary

Definition: The unlawful entry into a building with intent to commit theft or another felony.

Example: A burglar breaks into a home to steal electronics.

Z. Robbery

Definition: The taking of property from a person by force or threat of force.

Example: A robber holds up a convenience store at gunpoint.

AA. Mysterious Disappearance

Definition: The unexplained disappearance of insured property without evidence of theft.

Example: A piece of jewelry goes missing from a hotel room without any signs of forced entry.

BB. Binders

Definition: Temporary insurance contracts providing coverage until a permanent policy is issued.

Example: An auto insurance binder gives immediate coverage when purchasing a new car.

CC. Pro-rata Liability Clause

Definition: A clause specifying how losses will be shared among multiple insurance policies covering the same risk.

Example: Two insurance policies covering the same property divide the loss proportionally based on their coverage limits.

DD. Waiver and Estoppel

Definition:

Waiver: The voluntary relinquishment of a known right.

Estoppel: Preventing a party from asserting a right or fact that contradicts previous statements or behavior.

Example: An insurer waives the right to deny a claim by accepting late premium payments without penalty (waiver), and later cannot deny coverage based on those late payments (estoppel).

EE. Valued Policy

Definition: A policy that pays a pre-determined amount in the event of a total loss, regardless of the property's actual value at the time of the loss.

Example: A valued policy insures a painting for $10,000, paying this amount in a total loss, even if its current market value is different.

FF. Law of Large Numbers

Definition: A principle stating that the larger the number of exposure units, the more predictable the overall loss experience.

Example: Insurers use the law of large numbers to predict the likelihood of claims by analyzing a large pool of policyholders.

GG. Application

Definition: The form or document used to request insurance coverage, providing necessary details about the applicant and the risk.

Example: Filling out an auto insurance application with information about the driver, vehicle, and driving history.

2. Coverage

Definition: Coverage refers to the protection provided by an insurance policy against specified risks or losses.

a. Coverage A: Bodily Injury and Property Damage Liability (Occurrence, Claims Made including Retroactive Date)

Definition: This coverage protects the insured against claims for bodily injury or property damage caused by an occurrence during the policy period. It includes both occurrence-based and claims-made policies, with retroactive dates determining coverage for incidents occurring before the policy start date. **Example:** A business is sued for property damage caused by a delivery truck accident. Coverage A would cover legal defense costs and any settlements or judgments up to the policy limits.

b. Coverage B: Personal Injury and Advertising Injury

Definition: This coverage protects the insured against claims of personal injury (such as libel, slander, or invasion of privacy) and advertising injury (such as copyright infringement or false advertising). **Example:** A company is sued for defamation by a competitor due to false statements made in an advertisement. Coverage B would cover legal defense costs and any settlements or judgments up to the policy limits.

c. Coverage C: Medical Payments

Definition: This coverage provides for medical expenses incurred by third parties who are injured on the insured's premises or as a result of the insured's operations. **Example:** A customer slips and falls in a store, sustaining injuries. Coverage C would cover the customer's medical expenses up to the policy limits, regardless of fault.

d. Supplemental Payments

Definition: These are additional payments made by the insurer beyond the policy limits, covering costs such as legal defense fees, court costs, and other expenses incurred in the defense of a claim. **Example:** An insured is sued for negligence, and the insurer covers legal defense costs and court fees in addition to the policy limits.

e. Who is an Insured

Definition: This term defines who is covered under the insurance policy, including the named insured, employees, and sometimes other parties. **Example:** A business owner (named insured) and their employees are covered under the policy while performing job-related duties.

f. First Named Insured

Definition: The first named insured is the primary individual or entity listed on the policy and has the authority to make changes, file claims, and receive communications from the insurer. **Example:** In a business insurance policy, the business owner listed first is the first named insured and has the authority to manage the policy.

g. Limits (Per Occurrence, Annual Aggregate)

Definition: Limits refer to the maximum amount the insurer will pay for covered losses, either per occurrence (per individual claim) or annually (total claims within a policy year). **Example:** A policy with a per occurrence limit of $1 million and an annual aggregate limit of $2 million will pay up to $1 million for each claim and up to $2 million in total claims within a year.

h. Damage to Property of Others Conditions

Definition: These conditions outline the insurer's responsibilities and the insured's obligations when damage occurs to property owned by others. **Example:** If an insured's employee damages a customer's property while performing work, the policy conditions will detail how the insurer will handle the claim and any responsibilities of the insured.

A. Commercial General Liability (CGL) Quiz

Which of the following is not considered a product liability exposure?

A product distributed to a customer

Goods stored on the insured’s premises

Product consumed by a customer at a restaurant

Goods manufactured and sold to customers

Which of the following legal liability exposures is covered if bodily injury or property damage is caused by the insured’s negligent or faulty work?

Premises and Operations

Products

Completed Operations

Contingent liability

Which form provides coverage for a loss that takes place during the policy period and is not required to be reported within a limited time frame?

Supplemental Extended Reporting Period

Occurrence form

Claims-made form

Commercial General Liability form

Which of the following is not covered by personal injury liability?

Wrongful eviction

Copyright infringement

Malicious prosecution

Libel and slander

The most the insurer will pay during the policy period for medical expenses under Coverage A, B and C is which of the following limits of liability?

Personal and Advertising injury limit

Medical expense limit

General Aggregate limit

Per Occurrence limit

All of the following statements about the 60-day basic extended reporting period are true except:

It becomes effective automatically if needed when a claims-made policy expires

The insured must request it in writing within 60-days after the policy expires

It does not require an additional premium

No separate endorsement is required to provide the basic extended reporting period

A man suffers an injury when he swallows a piece of metal found in a bag of chips. This is an example of:

Premises and operations exposure

Products and completed operations exposure

Contingent liability exposure

Contractual liability exposure

All of the following reduce the Commercial General Liability's General Aggregate limit except:

The Medical Payments sublimit

The Personal and Advertising Injury limit

The Fire Damage limit

The Products and Completed Operations limit

Which of the following are excluded under Coverage A of the Commercial General Liability policy?

Damage the insured intentionally causes

Pollution losses caused by the insured

Liquor liability for those in the business of serving liquor

All of the above

If an insurer decides not to renew a Commercial General Liability policy, how many days'

notice must be given to the First Named Insured?

10 days

20 days

30 days

60 days

Which of the following is true concerning limits of insurance on a Commercial General Liability policy?

The limit for fire damage liability is per person

Personal and Advertising Injury has no limit

The medical expense limit is per occurrence

The Products and Completed Operations has the same per occurrence limit as Premises and Operations, but a separate Aggregate limit

On a Commercial General Liability claims-made form, the supplemental extended reporting period:

Is automatically built into the contract and has no additional premium charge

Is automatically built into the contract but has an additional premium charge

Requires an additional premium charge and must be added by endorsement

Provides an extra 60 days for claims to be reported

In liability policies, supplementary payments:

Are subject to the overall policy limit of liability

Have a separate limit of liability

Are payable in addition to the policy limit of liability

Are subject to a flat percentage of the limit of liability

A claims-made policy requires that the claim:

Occur within 60 days of the policy expiration date

Occur within 5 years of the policy expiration date

Occur within the policy period

Occur and be reported prior to the policy expiration date

All of the following are excluded under a Commercial General Liability policy except:

Bodily injury or property damage caused by the insured's operation of mobile equipment

Bodily injury to an employee that is covered by workers' compensation

Property damage to property that is in the care, custody, or control of the insured

Pollution liability

Products and Completed Operations covers all of the following except:

The cost of a recall

Liability related to property damage caused by the products you sold

Liability related to bodily injury caused by the products you sold

Cost of defense

Supplementary payments covered by a Commercial General Liability policy include:

The cost of an appeal bond

Loss of earnings up to $200 a day if the insurer requires the insured to attend a court hearing

$10,000 towards attorney's fees

Bodily injury and property damage related to products

If a business owner hires a cleaning service to clean their building and a customer slips and falls on a wet floor and sues the business owner, which portion of the Commercial General Liability policy would apply?

Products and Completed Operations

Premises and Operations liability

Independent contractors

Assumed liability

All are true about Coverage A, Bodily Injury and Property Damage, on a Commercial General Liability policy except:

The insurer needs the insured's consent to settle

The insurer has the duty to defend lawsuits in addition to the limits of liability

Loss must take place in the coverage territory

Supplementary payments are available in addition to the limits of liability

Auto: Personal Auto Quiz

What type of vehicle is a covered vehicle when your covered auto is being repaired due to a covered loss?

Substitute

Replacement

Temporary substitute

Conditional

Which of the following uses of a vehicle is not excluded under the Medical Payments coverage?

Insured uses a truck for incidental purposes

A neighbor uses the insured's car without permission

An insured drives a company car

An insured rides a motor cycle

Which of the following is covered under Part C – Uninsured motorist coverage?

Punitive damages awarded for the insured

The accident was caused by a hit-and-run driver

The insured is also covered by workers' compensation

A family member is struck by an insured vehicle

After an automobile policy has been in effect for 60 days, the insurer may cancel the policy for any of the following reasons except:

Non-payment of premium

Material misrepresentation of information on the application by the insured

Submission of four or more claims during a single policy period

Suspension of the driver's license of the named insured or household resident

In auto insurance, limits of 50/100/25 mean the insured is covered for:

$50,000 property damage, $100,000 bodily injury and $25,000 collision damage per occurrence

$50,000 bodily injury, $100,000 personal liability and $25,000 property damage per policy period

$50,000 bodily injury per person, $100,000 bodily injury per occurrence and $25,000 property damage per occurrence

$50,000 property damage per occurrence, $100,000 bodily injury per occurrence and $25,000 bodily injury per person

Under a Personal Auto Policy, if you negligently hit a tree, causing your passenger bodily injury, which of the following statements is true?

Your Personal Auto Policy will cover the passenger's bodily injury and loss of earnings up to your bodily injury per person limit

Only medical payments will apply to your passenger

There is no coverage at all for your passenger

Your passenger's Personal Auto Policy will cover the injuries

You negligently cause an accident resulting in bodily injury and property damage to the maximum of your policy limits, which are 30/60/20. If your defense costs in a resulting lawsuit are $8,000, how much will your insurer pay?

$80,000

$88,000

$110,000

$118,000

All of these are covered to drive your covered auto on your Personal Auto Policy except:

Your son

Your neighbor

Your friend using your car on a temporary basis

Your auto mechanic test driving your car

All of these are true regarding medical payments coverage on a Personal Auto Policy except:

Coverage is to others, not you

Coverage is for you and your passengers

It is an optional coverage

It covers necessary medical and funeral expenses

Under a Personal Auto Policy, which of the following is considered to be a collision loss?

Another driver dents your fender and drives off

Another driver sideswipes you as you are getting out of your car

Your car hits a large animal, crushing the grill and headlights

Children playing ball break the windshield of your parked car

A friend borrows your car and causes an accident while driving it. Whose insurance covers the damage?

Only the friend's insurance applies

Only your insurance applies

Your policy applies first, and your friend's applies to any excess

Your friend's applies first and yours applies to any excess

Your fully insured car is hit by an uninsured motorist. Your insurance company:

Pays your bodily injury and property damage under your Part C – Uninsured motorists coverage

Pays your bodily injury under your Uninsured motorists and your property damage under your Part D – Damage to your auto

Pays your bodily injury only

Pays your property damage only

Besides any vehicle shown on the Declarations page, the liability part of your Personal Auto Policy will cover any of the following except:

An additional car or truck you buy during the policy period and request the insurer to add to the policy

A replacement car or truck you buy during the policy period, even if you do not notify the insurer

A motor home you buy during the policy period and request the insurer to add to the policy

A temporary substitute vehicle you borrow or rent while your covered auto is out of commission

You have a Personal Auto Policy with Underinsured motorists coverage of 50/100. If another negligent party with Personal Auto Policy bodily injury limits of 15/30 causes you bodily injury in the amount of $40,000, how much can you recover from your Uninsured motorists coverage?

$15,000

$25,000

$50,000

$100,000

On a Personal Auto Policy, which of the following is not covered under Other than Collision coverage?

Theft of a portable car phone

Missiles and falling objects

Collision with a deer

Flood

Even if they have bad driving records, drivers can purchase auto insurance in most states from:

A FAIR plan

An Automobile Insurance Plan

A State Guaranty Association

An option to self-insure

On your Personal Auto Policy, all are true regarding the Other than Collision and Collision coverages except:

Both are usually subject to a deductible

Coverages are provided on an actual cash value basis

The deductible must be the same on both coverages

The deductibles are stated separately

All are true about a Personal Auto Policy except

The owner's policy is primary

Transportation expenses are covered for a definite amount and time

Supplementary payments are included

Cancellation notice must be sent to all insureds

Personal Auto medical claims must be turned in within ___ years of the date of an accident:

1

2

3

5

On a Personal Auto Policy, all of the following are covered by the medical payments except:

The named insured or family members while occupying a motor vehicle

The named insured or family members when struck as a pedestrian

Passengers riding in the insured's covered auto

Persons riding in an auto with which the insured has collided

The named non-owner endorsement may be added to a Personal Auto Policy to provide coverage for:

Relatives of the named insured who do not live in the same household

Someone who does not own an automobile, but drives borrowed or rented autos

Young drivers in the household who do not own their own car

Non family members who use the insured's auto with permission

On a Personal Auto Policy, when you loan your covered auto to another person who also has a Personal Auto Policy covering their own car:

Your policy is primary

Your policy will not cover if the other person has the regular use of your car

The other person's policy is primary

The other person is not covered unless they are named on the Declarations page of your policy

All are true about coverage under a Personal Auto Policy except:

There is no coverage in Mexico

Coverage applies while using your car in a share the expense car pool

Medical coverage applies to others, not the named insured

Permanently installed stereo systems are covered

Auto: Commercial Quiz

The Business Auto Coverage form liability coverage covers which of the following:

Property damage to the insured's property

Mobile equipment being transported or towed by the insured

Bodily injury to the insured

Workers' compensation

Garage liability coverage is broader than the Business Auto Coverage liability coverage because it:

Is not written with deductibles

Has additional supplementary payments

Provides coverage for damage to customers' autos

Provides some coverage for premises, products, and completed operations

The name of the policy that is usually written on a blanket basis to protect auto dealers and repair shops for legal liability as a result of damage to a customer's car is called:

Commercial general liability

Garagekeepers liability

Garage liability

Business auto coverage

Under Business auto coverage each of the following is true about classifications of covered autos except:

Mobile equipment is considered to be covered as a covered auto

Any auto is the broadest coverage classification

The insured may select several different classifications of covered autos

Hired autos includes autos leased, hired, rented, or borrowed by the insured

What is the maximum the insurer will pay for a covered transportation expenses claim:

$200

$400

$600

$800

Which of the following is true about the Individual Named Insured endorsement?

Protects the named insured who does not own a car

Applies to all resident family members

Adds business coverage to a personal private passenger auto

Coverage is provided only to those individuals listed on a schedule

If an insured wants collision coverage for only a few autos out of a fleet of autos, which symbol would be used in the declarations?

1

7

5

9

Eddie is driving his company-owned truck in another state and causes an accident. That state requires a minimum of $30,000 liability coverage and his policy has a limit of $25.000. Eddie is sued for $50,000 damages arising out of the accident. How much will the insurer pay?

$25,000

$30,000

$50,000

$0

A covered auto collided with a bird and the windshield was damaged. The auto is insured for collision and comprehensive coverages under the Business Auto Coverage form. Which coverage would pay for the loss?

Collision

Comprehensive

Both collision and comprehensive

Neither collision nor comprehensive

All are true of the Business Auto Coverage form conditions except:

An insured cannot take legal action against the insurer unless they have fully complied with all terms of the policy

The Business Auto Coverage form provides excess coverage for covered autos owned by the insured

When the Business Auto Coverage form and other insurance cover on the same basis, the Business Auto Coverage form pays only its share of the loss based on the proportion of its coverage

If more than one policy issued by the same insurer applies to a loss, the amount the insured will be paid is limited to the highest single policy limit

The insured has a Business Auto Coverage form that covers all autos. A salesperson working for the business is provided with a company car. The salesperson borrows a neighbor's car and, while using it on company business, has an accident. Which of the following is correct?

The salesperson has liability damage under an unendorsed Business Auto Coverage form

The salesperson has property damage coverage under an unendorsed Business Auto Coverage form

The salesperson would have liability coverage under a Business Auto Coverage form with the Drive Other Car Coverage endorsement

The salesperson would have liability coverage under a Business Auto Coverage form with the Employees as Additional Insureds endorsement

Which portion of the Garage coverage form covers liability for damage to property of others in the insured's care, custody or control?

Liability

Garagekeepers

Physical damage

Garage operations

Which of the following perils is not included in the Business Auto Coverage form's

Specified Causes of Loss coverage?

Collision

Earthquake

Flood

Theft

All of the following would be considered an insured under Business Auto liability coverage except:

The named insured

Others while using a covered auto with permission

The owner of a borrowed vehicle

Others who become liable for the conduct of an insured

The Business Auto coverage form covers all of the following except:

Owned private passenger autos

Mobile equipment registered to drive on public roads

Automatic coverage for physical damage to trailers

Workers Compensation / Employers Liability Quiz

Generally an employer is required by state law to provide workers' compensation insurance if it has __ or more employees.

1

3

5

50

Loss of income benefits on workers' compensation are usually covered to what percentage of the average weekly wages?

50%

100%

66 2/3%

75%

Workers' compensation medical benefits:

Are subject to deductibles and coinsurance

Are subject to annual maximum amounts

Are subject to a lifetime maximum amount

Have no dollar or time limit on covered expenses

All are true of workers' compensation insurance except:

It is required by state law

Coverage is statutory

An injured worker must prove that the employer was negligent

It pays regardless of fault

Employer's liability pays for all of the following for which the insured is legally obligated to pay except:

Care and loss of services

Injuries claimed by a third party as a result of worker's injuries

Consequential injury to dependents

Intentional injury by the employee

Surety Bonds Quiz

What is the primary purpose of surety bonds?

A. To provide financial assistance to contractors

B. To guarantee the completion of a project as specified in the contract

C. To ensure project owners make timely payments

D. To cover the cost of materials used in a project

In which industry are surety bonds commonly used?

A. Retail

B. Healthcare

C. Construction

D. Technology

E. Crime coverage Quiz

Which of the following has the care and custody of the insured's property outside the premises?

Employee

Watchperson

Custodian

Messenger

Each of the following is true of a Discovery crime coverage form except:

Covers a loss that was discovered within one year of the expiration of the policy

Covers a loss that was discovered during the policy period

Might require the use of a retroactive date

Covers a loss that did not necessarily occur during the policy period

The Inside the Premises – Theft of money and securities insuring agreement covers each of the following types of loss, except:

Theft of money inside the insured's premises committed by a person present on the premises

Theft of money or securities by an accountant

Damage to the insured's premises or its exterior caused by a theft or attempted theft

Damage to a locked safe or vault caused by a theft or attempted theft

Which of the following type of crime coverage requires signs of forcible entry or exit?

Mysterious disappearance

Robbery

Burglary

Theft

Employee theft or dishonesty covers all of the following except:

Theft of money

Theft of securities

Robbery

Employee pilferage

On a commercial crime policy, money is defined as all of the following, except:

Currency

Coins

Evidence of debt

Travelers checks

A group of teenagers broke into a gas station store by driving through the front door

after the store was closed. They stole some snacks and drinks for a loss of $70, $20 of coins in a container on the counter, and tried, unsuccessfully, to break into the safe. Which of the following losses would not be covered under Inside the Premises – Theft of money and securities coverages?

Damage to the front door

Damage to the safe

$70 for the loss of the snacks and drinks

$20 for the loss of the cash on the counter

Coverage for defense costs is included in:

Computer fraud coverage

Forgery or alteration coverage

All of the crime coverages

None of the crime coverages

Who of the following would not be considered a custodian while having the care and custody of company property inside the premises?

A store clerk

A company director

A stock clerk

A janitor

What type of property is protected under computer fraud coverage?

Money

Securities

Other property

All of the above

Umbrella/Excess Quiz

What is not true of a personal umbrella policy?

a) The policy forms are standardized

b) The policy requires underlying coverage for homes and automobiles

c) The umbrella policy can provide broader coverage than the insured's primary policies

d) They usually have lower limits written on an excess basis

What is a requirement for qualifying for a personal umbrella policy?

a) Having primary liability coverage for boats

b) Having primary liability coverage for homes and automobiles

c) Owning multiple properties

d) Having no other insurance coverage

What does commercial umbrella insurance provide?

Additional protection beyond primary liability policies

Basic liability coverage only

Coverage with lower limits than primary policies

Coverage that is limited to specific industries

What is the main difference between commercial umbrella and commercial excess liability insurance?

Commercial excess insurance provides broader coverage than umbrella insurance

Commercial umbrella insurance follows the same terms and conditions as primary policies

Commercial excess insurance is suitable for businesses of all sizes

Commercial umbrella insurance is purchased by businesses needing higher liability limits

Coercion

Definition: Coercion in insurance refers to the act of using physical or mental force to persuade someone to purchase insurance coverage. This practice is illegal and unethical.

Example: An insurance agent threatens a potential customer with negative consequences if they do not buy a policy from them.

What is coercion in relation to insurance?

You might be aware that coercion can happen in the workplace or in other aspects of your life, but it can also occur in the realm of insurance. In regard to insurance, coercion transpires when someone in the insurance business applies either physical or mental force — or the threat of force — to persuade an individual to purchase insurance coverage. Any action that the agent inflicts through coercion is considered illegal.

Types of Coercion

Coercion occurs in many ways. These are the most common ways that coercion happens in insurance.

Psychological coercion

The first way that an insurance agent can use coercion to convince an individual to transact insurance is through psychological pressure. And this would directly affect the mental and emotional state of the person due to the duress. It is easier to persuade a person to unwillingly purchase insurance if their mental state is compromised.

Blackmail

Another way to coerce a person into buying insurance is through blackmail. Blackmail is demanding something from another individual in return for not revealing embarrassing or compromising information about them. An insurance agent could possibly use the information they learn about a potential customer to "convince" them to buy a policy or to spend more money than they intend to expend.

Unknowingly upgrade

Instead of blackmail, an insurance broker could include upgrades and more expensive benefits without the new policyholder's knowledge. Then, once the policyholder finds out, they may be too intimidated to say anything about it.

Threats

Some insurance agents may use threats and force to make a person take out an insurance policy. This usually happens after they attempt a normal sale of the policy and the agent resorts to using power to get them to agree to go through with it.

What are some examples of insurance coercion?

In order to really know what insurance coercion is, let's consider some coercion scenarios:

Blackmail. An insurance agent is selling company insurance packages for its employees. The CEO doesn't want to comply with it, but the agent reveals that they have pictures of him with a woman who isn't his wife. If the CEO buys the insurance, the agents won't release the photos. This is an example of coercion through blackmail.

Psychological coercion. Someone with little to no knowledge of insurance is trying to purchase a policy. If an insurance agent takes advantage of that unenlightenment to manipulate them into purchasing a plan that the person doesn't need, that's psychological coercion. The agent might even attempt to gaslight them into thinking that it's the best option for them.

Threatening behavior. Maybe a policyholder wants to cancel their policy and get insurance elsewhere. If the insurance company or agent says that there will be consequences — aside from a cancellation fee — this is coercion through threatening behavior.

Unintentional upgrade. Let's say that an older couple wants a life insurance policy. They are slightly confused about the process, and the agent intentionally adds more expensive benefits that the couple isn't aware of. Then, they find out after the first payment and don't know what to do, so they don't do anything at all and continue paying the higher premium.

Unveiling Insurance Coercion

Coercion in the realm of insurance encompasses a spectrum of unethical practices designed to manipulate consumers, often leaving them vulnerable to exploitation and financial harm. From boycotting in insurance to insurance fraud scams, various tactics are employed to coerce individuals into unfavorable agreements.

Predatory insurance practices, such as twisting definition in insurance and insurance term twisting, distort policy terms to the detriment of policyholders. Additionally, instances of insurance scandal reveal systemic abuses within the industry, prompting the need for insurance fraud investigator interventions.

Knowing how to report insurance fraud and understanding insurance rebating laws by state are crucial steps in combatting coercion and holding life insurance companies accountable. In extreme cases, victims may resort to legal action, learning how to sue a life insurance company in pursuit of justice and restitution.

Understanding Coercion in Insurance

When discussing what is coercion in insurance, it is essential to understand the adverse practices that can undermine fair dealing. The coercion meaning in insurance refers to the unethical act of compelling an individual to purchase or terminate an insurance policy against their will.

To delve deeper into the coercion definition insurance, it involves manipulating or threatening tactics that forcefully influence a person's decision regarding their insurance coverage.

To define coercion in insurance, it is the use of undue pressure to sway a person's insurance choices, which is not only unethical but also illegal.

An instance of this can be seen in a twisting insurance example, where an agent might coerce a policyholder into replacing their current policy with a less favorable one under false pretenses, thus benefiting the agent at the expense of the insured.

The Impact of Coercion in the Insurance Industry

Coercion in the insurance industry can manifest in various detrimental practices, such as unfair settlement practices and car insurance fraud. Particularly, coercion insurance refers to situations where policyholders are pressured into unfavorable agreements.

Understanding coercion insurance definition is crucial for both consumers and professionals to identify and combat these issues.

For instance, coercion in life insurance can lead to significant financial and emotional distress for policyholders. Legal frameworks like the California anti-coercion insurance disclosure and anti-coercion insurance disclosure requirements aim to protect consumers.

According to Best Insurance Guide ratings, transparency and ethical practices are paramount in fostering trust. Unfortunately, the presence of car insurance scams and coercion of debtors highlights the ongoing challenges within the sector.

Understanding Coercion in the Insurance Sector

Coercion in the insurance sector encompasses various unethical and illegal activities, such as insurance claim fraud and unfair practices in insurance.

An example of this is trying to coerce a person to buy an insurance policy, which undermines consumer autonomy. In complex scenarios like life insurance misrepresentation or cases involving molestation insurance, the need for insurance legal advice becomes critical.

Additionally, insurance subrogation can lead to disputes where coercion might play a role. To safeguard against these practices, the anti-coercion notice must be signed to ensure transparency and fairness. Furthermore, protective claims can help shield consumers, while recognizing psychological coercion example scenarios is essential for maintaining ethical standards in the industry.

Is coercion illegal in the insurance business?

Coercion can be a misdemeanor or a criminal offense depending on the situation. If someone uses coercion to get another person to commit a felony, then that is a serious criminal offense and can result in jail time. In the insurance business, it is considered an illegal trade act practice.

What is rebating in insurance?

In the insurance industry, coercion isn't the only unethical or illegal practice that can occur. Another deceptive practice that companies and agents use to convince people to buy insurance is called rebating. Rebating is the act of offering something of value to the prospective insurance buyer that isn't included in the policy. In every state except Florida and California, which have strict guidelines, rebating in insurance is illegal and prohibited.

The following is a list of rebating scenarios:

- A prospective insurance buyer receives a refund of some or all of the commission for the insurance sale
- An insurance broker offers a cash gift
- Offering Gifts
- Providing services
- Payment of premiums
- Employment offers
- Any other item of value

The National Association of Insurance Commissioners (NAIC) promoted the Model Act. Under the Model Act, the rebating action of dividing commission and giving money to the consumer to purchase insurance is considered a deceptive practice and an unfair method of competition.

What's the difference between twisting and churning in insurance?

If you've been researching illegal insurance practices, you may have come across the terms twisting and churning. Although they are both somewhat similar activities, they occur under different circumstances and for different reasons.

Twisting

Are you wondering what is twisting in insurance? Twisting is the act of persuading a policyholder to replace their policy for a similar one, often with misleading information. Typically, it's not in the customer's best interest to switch policies, but they are convinced through deception. Twisting is beneficial for the insurance agent but can be harmful to the policyholder, who can lose time and money.

Churning

Churning in insurance occurs when an insurance broker purposefully replaces a policyholder's insurance policy for another policy with another insurer. Usually, this is done without the knowledge of the policyholder and doesn't actually change any of the coverage. It merely provides the agent another commission for the policy that they swap, which is totally illegal.

Can there be defamation in insurance?

In short, yes, defamation can occur in insurance. But what is defamation in insurance? Defamation is a false statement about someone that harms their reputation.

There are two types of defamation, including slander (oral statements) and libel (written statements). Insurance can cover you from defamation. It usually falls under liability or personal injury coverage and can protect against damages caused by defamation.

How to report illegal insurance activity

If you or someone you know is a victim of illegal insurance activity, various organizations can assist you. Many states have fraud and abuse helplines that you can easily find through a simple Google search. For example, Pennsylvania has a web page on its Department of Human Services site with a tipline to report provider or recipient fraud. You can also report illegal insurance acts to the FBI or to the National Association of Insurance Commissioners (NAIC).

Is coercion legal in insurance?

No, coercion is not legal in insurance. Insurance companies are required to provide customers with full and accurate information about their policies and coverage options, and to allow customers to make their own decisions without coercion.

What should I do if I believe I have been coerced into buying an insurance policy?

If you believe you have been coerced into buying an insurance policy, you should contact your state insurance department or regulatory agency to file a complaint. You may also want to consider contacting a lawyer who specializes in insurance law for further guidance.

Can an insurance agent be held liable for coercion?

Yes, an insurance agent can be held liable for coercion if they engage in coercive behavior when selling insurance policies. In some cases, insurance companies may also be held liable for the actions of their agents.

What does coercion mean in insurance?

Coercion in insurance refers to the practice of forcing or intimidating someone into making a decision about their insurance policy that they would not have made voluntarily.

Is coercion of debtors an unfair trade practice?

Yes, coercion of debtors is considered an unfair trade practice as it involves unethical pressure to force someone to fulfill debt obligations.

Can I sue my insurance company for emotional distress?

Yes, you can sue your insurance company for emotional distress if their actions, such as bad faith practices or unfair treatment, have caused you significant emotional harm.

Can I sue my insurance company for dropping me?

Yes, you can sue your insurance company for dropping you if it was done without a valid reason or in violation of your policy terms and applicable laws.

What is an example of coercion?

An example of coercion is a lender threatening a borrower with legal action to force them to take an insurance policy from a specific provider.

What is coercion in life insurance?

Coercion in life insurance involves pressuring an individual to purchase or modify a life insurance policy against their will.

What can coercion include?

Coercion can include threats, intimidation, physical force, or psychological pressure to compel someone to act in a certain way.

What is the principle of coercion?

The principle of coercion is the use of force or threats to make someone do something against their will.

What is the most common form of coercion?

The most common form of coercion is psychological pressure, such as threats or intimidation, to influence someone's actions.

What is an alternative for coercion?

An alternative for coercion is persuasion, which involves convincing someone through reason and argument rather than force or threats.

Who is at risk of coercion?

Individuals in vulnerable positions, such as debtors, employees, or dependents, are at higher risk of coercion.

Who uses coercion?

Coercion can be used by individuals or entities in positions of power or authority, such as employers, creditors, or even family members.

What is considered an act of coercion?

An act of coercion involves using threats, intimidation, or force to compel someone to act against their will.

Which situation is an example of coercion?

An example of coercion is an employer threatening to fire an employee unless they agree to unfair working conditions.

Is coercion a threat?

Yes, coercion often involves the use of threats to force someone to comply with demands.

What can be considered coercion?

Coercion can be considered any act that uses force, threats, or intimidation to compel someone to do something against their will.

Is coercion a form of harassment?

Yes, coercion can be a form of harassment if it involves persistent and aggressive pressure or intimidation.

What is an example of coercion in business?

An example of coercion in business is a dominant company threatening to withdraw its business unless a supplier agrees to significantly lower prices.

What is an example of coercion in business?

An example of coercion in business is a supplier threatening to cut off essential supplies to a retailer unless they agree to higher prices or unfavorable contract terms.

What is an example of coercion and threats?

An example of coercion and threats is a landlord threatening to evict a tenant unless they pay an

additional, unauthorized fee.

What is an example of coercion in society?

An example of coercion in society is a gang member threatening harm to someone's family unless they join the gang or carry out illegal activities.

What is a coercion example in contract?

A coercion example in contract is forcing someone to sign a contract under the threat of physical violence or financial ruin.

What is the law of coercion?

The law of coercion refers to legal provisions that protect individuals from being forced into agreements or actions against their will, typically rendering any such agreements voidable.

What are the consequences of coercion?

The consequences of coercion can include legal penalties for the coercer, invalidation of coerced agreements, and potential compensation for the victim.

What is coercion in human behavior?

Coercion in human behavior involves using force, threats, or intimidation to influence someone's actions, often leading to stress, fear, and resentment.

What are grounds of coercion?

Grounds of coercion include situations where an individual is forced into an action due to threats, physical force, or psychological pressure.

Is coercion free consent?

No, coercion is not free consent, as it involves compelling someone to act against their will through threats or force.

What is the problem with coercion?

The problem with coercion is that it undermines free will and autonomy, often leading to unfair and unjust outcomes, and can be legally and ethically problematic.

Commingling

Definition: Commingling in insurance is the practice of mixing funds from different sources, such as premiums collected from policyholders, with the insurer's own funds. This can lead to financial instability and lack of transparency.

Example: An insurance company uses premiums collected from policyholders to cover its operational expenses instead of keeping them separate for claim payments.

Understanding the Concept of Commingling in Insurance

Understanding the concept of commingling in insurance is crucial for both insurance providers and policyholders. Commingling refers to the practice of mixing funds from different sources, such as premiums collected from policyholders, with the insurer's own funds. While this may seem like a harmless administrative process, it can have significant consequences that impact the stability and reliability of an insurance company.

From the perspective of insurance providers, commingling can be seen as a way to streamline financial operations and manage cash flow more efficiently. By pooling funds together, insurers

can allocate resources as needed, ensuring that claims are paid promptly, and operational expenses are covered. However, this practice also poses risks that need to be carefully considered.

Increased vulnerability to insolvency: Commingling funds exposes insurance companies to a higher risk of insolvency. If an insurer faces financial difficulties or becomes insolvent, the mingled funds could be used to cover other obligations instead of being solely reserved for claim payments. This jeopardizes the ability to fulfill policyholder claims and undermines trust in the company.

Lack of transparency: Commingling can make it challenging for policyholders to understand how their premiums are being utilized. Without clear separation between policyholder funds and insurer assets, it becomes difficult to track where exactly the money is going. This lack of transparency can lead to concerns about mismanagement or potential fraud.

Inadequate reserves: When funds are commingled, it becomes harder to accurately assess an insurer's financial health and determine if they have sufficient reserves to cover potential losses. Insufficient reserves can result in delayed claim payments or even bankruptcy in extreme cases.

To illustrate these points, let's consider an example. Imagine a small insurance company that commingles its funds without proper oversight or controls in place. Due to poor investment decisions or unforeseen circumstances, the company experiences significant financial losses.

As a result, they are unable to meet their claim obligations, leaving policyholders without the coverage they paid for and causing reputational damage to the company.

Understanding the concept of commingling in insurance is essential to grasp the potential risks and consequences associated with this practice. By recognizing the vulnerabilities, it introduces, both insurance providers and policyholders can work towards ensuring greater transparency, financial stability, and trust within the industry.

The Risks and Dangers of Commingling Funds in Insurance Companies

Commingling funds in insurance companies can have significant risks and dangers that need to be carefully considered. When insurance companies commingle funds, they combine policyholders' premiums with their own capital, creating a pool of money that is used to pay claims and cover operational expenses. While this practice may seem convenient for insurers, it can lead to several negative consequences from various perspectives.

Lack of Transparency: Commingling funds can make it difficult to track the flow of money within an insurance company. Policyholders may not have a clear understanding of how their premiums are being utilized or whether their funds are being adequately protected. This lack of transparency can erode trust between insurers and policyholders, potentially leading to customer dissatisfaction and even legal disputes.

Financial Instability: By commingling funds, insurance companies expose themselves to financial instability. If an insurer faces unexpected financial challenges or a large number of claims, the commingled funds may not be sufficient to cover all obligations. In such cases, policyholders could face delays in claim settlements or even the possibility of not receiving their entitled benefits.

Cross-Subsidization: Commingling funds can result in cross- subsidization, where the premiums paid by one group of policyholders are used to cover the claims and expenses of another group. This practice can create inequities among policyholders, as some may end up subsidizing others without their knowledge or consent. For example, if a life insurance company

commingles funds from both term life and whole life policies, the higher premiums paid by whole life policyholders could be used to cover claims for term life policies.

Regulatory Concerns: Regulators closely monitor insurance companies to ensure they maintain solvency and protect policyholders' interests. Commingling funds can raise regulatory concerns as it becomes challenging for regulators to assess an insurer's financial health accurately. Without clear separation between policyholder funds and insurer capital, it becomes difficult to determine if an insurer has sufficient reserves to meet its obligations.

Contagion Risk: Commingling funds can also expose policyholders to contagion risk. If an insurance company faces financial distress or insolvency, commingled funds could be at risk of being used to cover the insurer's debts or obligations unrelated to policyholder claims. This scenario could potentially result in policyholders losing a portion or all of their invested premiums.

While commingling funds may offer operational convenience for insurance companies, it comes with inherent risks and dangers

Commingling and Regulatory Compliance

Commingling of funds in the insurance industry can have significant legal implications and regulatory compliance concerns. It is crucial for insurance companies to understand the potential consequences of commingling and ensure they adhere to the necessary regulations to avoid any legal repercussions.

From a legal standpoint, commingling refers to the mixing of funds or assets from different sources into a single account. In the insurance context, this typically involves combining premiums received from policyholders with other company funds. While commingling may seem like a convenient practice for insurers, it can lead to various legal challenges and regulatory compliance issues.

Breach of Fiduciary duty: Insurance companies have a fiduciary duty to act in the best interests of their policyholders. Commingling funds can potentially breach this duty by jeopardizing the ability to accurately track and allocate policyholder premiums. If an insurer fails to segregate these funds properly, it may be seen as a violation of its fiduciary obligations.

Misappropriation of Funds: Commingling can create opportunities for misappropriation or misuse of funds. Without clear separation between policyholder premiums and other company assets, there is a risk that funds intended for claim payments or policyholder benefits could be diverted for other purposes.

This not only raises ethical concerns but also exposes insurers to potential lawsuits and regulatory penalties.

Regulatory Compliance: Insurance regulators impose strict guidelines on how insurers handle policyholder funds. Commingling without proper oversight and controls can result in non-compliance with these regulations. For instance, many jurisdictions require insurers to maintain separate trust accounts or segregated accounts specifically designated for policyholder premiums. Failure to comply with such requirements can lead to regulatory sanctions, fines, or even license revocation.

Financial transparency: Commingling can complicate financial reporting and transparency efforts. When funds are mixed together, it becomes challenging to provide accurate financial statements that clearly reflect the true financial position of the insurer. This lack of transparency can erode trust among policyholders, investors, and regulators, potentially damaging the reputation and credibility of the insurance company.

To illustrate the potential consequences of commingling, consider a hypothetical scenario where an insurance company commingles policyholder premiums with its general operating funds.

If the insurer faces financial difficulties or bankruptcy, it may be unable to distinguish between policyholder funds and its own assets. As a result, policyholders could face delays or even loss of their claims payments due to the commingling practices.

How Commingling Affects Policyholders and Insurers?

Commingling, the practice of mixing funds from different sources, can have significant financial consequences for both policyholders and insurers in the insurance industry. This section will delve into the various ways in which commingling affects these stakeholders, providing insights from different points of view.

Policyholder Vulnerability: When an insurer commingles funds, it becomes challenging to distinguish between the assets belonging to policyholders and those of the company. This lack of transparency can leave policyholders vulnerable in case of insolvency or bankruptcy. In such situations, policyholders may face delays or even difficulties in receiving their claims as their funds are entangled with those of other policyholders or creditors.

For example, imagine a scenario where an insurance company commingles its funds and subsequently faces financial distress. In this case, policyholders may find themselves at the mercy of bankruptcy proceedings, potentially leading to reduced claim payouts or even total loss of coverage.

Insurer Solvency Risks: Commingling funds can also pose risks to insurers themselves. By mixing policyholder premiums with general operating funds, insurers may inadvertently expose themselves to liquidity issues or mismanagement of funds. If an insurer fails to properly segregate these funds, it could lead to a situation where they are unable to meet their financial obligations towards policyholders.

Consider a situation where an insurer commingles premium payments with operational expenses without maintaining adequate reserves. If a catastrophic event occurs that requires substantial claim payouts, the insurer may struggle to fulfill its obligations due to insufficient available funds.

Regulatory Compliance: Commingling can have legal and regulatory implications for insurers. Many jurisdictions have strict regulations in place that require insurers to maintain separate accounts for policyholder funds.

Failure to comply with these regulations can result in penalties, fines, or even revocation of licenses.

For instance, suppose an insurance company is found guilty of commingling policyholder premiums with corporate funds in violation of regulatory requirements. In such a case, the company may face severe penalties, damaging its reputation and potentially leading to loss of business.

Trust and Reputation: Commingling funds can erode trust between insurers and policyholders. Policyholders expect their premiums to be handled responsibly and used exclusively for the purpose of paying claims. When an insurer commingles funds, it raises concerns about the integrity of the company's financial practices, potentially leading to a loss of confidence among policyholders.

The Importance of Separating Funds

Transparency and accountability are crucial aspects of any financial system, and the insurance industry is no exception. In order to ensure the integrity of funds and maintain trust with policyholders, it is essential to separate funds within an insurance company. This separation serves as a safeguard against commingling, which can have severe consequences for both insurers and policyholders.

From the perspective of policyholders, the separation of funds provides a clear distinction between their premiums and the insurer's assets. This transparency allows policyholders to have confidence that their premiums are being used solely for the purpose of covering potential claims and not being mixed with other funds for unrelated purposes. By separating funds, insurers can demonstrate their commitment to fulfilling their obligations to policyholders and avoid any perception of impropriety.

Insurers also benefit from separating funds as it enables them to accurately assess their financial position. By maintaining separate accounts for premiums, insurers can easily track the amount of money available for claims payments and ensure they have sufficient reserves to meet their obligations. This level of transparency allows insurers to make informed decisions about pricing policies, managing risk, and maintaining solvency.

To delve deeper into the importance of separating funds in insurance, here are some key points:

Protection against insolvency: Separating funds helps protect policyholders in the event of an insurer's insolvency. If an insurer were to commingle funds, it could lead to a situation where there are insufficient assets available to cover claims. By keeping premiums separate, policyholders' funds remain ring-fenced and can be used exclusively for claim settlements.

Regulatory compliance: Many jurisdictions have regulations in place that require insurers to maintain separate accounts for premiums. These regulations aim to ensure transparency, prevent fraud, and protect policyholders' interests. Non-compliance with these requirements can result in penalties or even revocation of an insurer's license.

Trust and reputation: Maintaining separate funds enhances an insurer's reputation and builds trust with policyholders. When policyholders have confidence that their premiums are being handled responsibly, they are more likely to renew their policies and recommend the insurer to others. On the other hand, commingling funds can lead to a loss of trust, damaging an insurer's reputation and potentially leading to a loss of business.

Legal implications: Commingling funds can have legal ramifications for insurers. In the event of a lawsuit or regulatory investigation, the separation of funds can provide clear evidence of compliance with financial regulations and help protect an insurer from legal liabilities.

Real-Life Examples of Commingling Gone Wrong

Commingling, the practice of mixing funds or assets from different sources, is a common occurrence in various industries, including insurance. While it may seem like a convenient way to manage finances, commingling can have severe consequences when done improperly. In this section, we will delve into real-life case studies that highlight the detrimental effects of commingling gone wrong.

The Collapse of MF Global: One of the most infamous examples of commingling gone awry is the case of MF Global, a global financial derivatives broker. In 2011, MF Global filed for bankruptcy after it was discovered that they had commingled customer funds with their own accounts.

This unauthorized use of client funds amounted to approximately $1.6 billion and resulted in significant losses for thousands of customers. The incident not only led to legal repercussions for the company's executives but also eroded trust in the financial industry as a whole.

Insurance Fraud Scams: Commingling can also be a breeding ground for insurance fraud schemes. In these cases, unscrupulous individuals or companies may commingle premium payments with personal funds, making it difficult to distinguish between legitimate business operations and fraudulent activities. For example, an insurance agent might collect premiums from policyholders but instead of depositing them into a separate trust account, they mix them with their personal funds. This can lead to delays in claim settlements or even the complete loss of coverage for policyholders if the agent misappropriates the funds.

Ponzi Schemes: Commingling is often a key component of Ponzi schemes, where fraudsters use funds from new investors to pay returns to earlier investors. By commingling investor funds with their own personal accounts, these schemers create an illusion of profitability and legitimacy. However, when new investments dry up or withdrawals exceed new inflows, the scheme collapses, leaving unsuspecting investors with substantial losses.

Non-Profit Mismanagement: Commingling can also have dire consequences in the non-profit sector. For instance, a charitable organization may commingle donations with operational funds, making it challenging to track how donor contributions are being utilized. This lack of transparency can lead to mismanagement, misuse of funds, and ultimately damage the reputation of the organization.

Legal and Ethical implications: Commingling gone wrong not only has financial repercussions but also raises legal and ethical concerns. In many jurisdictions, commingling client funds with personal or business accounts is strictly prohibited, as it undermines

Best Practices for Insurance Companies

Preventing commingling is a crucial aspect of risk management for insurance companies. Commingling occurs when an insurer mixes policyholders' funds with its own assets, leading to potential financial instability and legal complications.

To ensure the integrity of their operations and protect the interests of policyholders, insurance companies must adopt best practices that promote transparency, accountability, and compliance with regulatory requirements.

From the perspective of policyholders, preventing commingling is essential to safeguard their investments and ensure that claims can be paid promptly. When an insurer commingles funds, it becomes challenging to determine the exact amount available for claim settlements. This lack of clarity can lead to delays or even denials in claim processing, causing significant distress for policyholders who rely on insurance coverage during times of need.

On the other hand, from the viewpoint of regulators, preventing commingling is crucial to maintain stability within the insurance industry. Regulators impose strict guidelines to prevent insurers from using policyholders' funds for purposes other than fulfilling their contractual obligations. By adhering to these guidelines, insurers demonstrate their commitment to maintaining financial solvency and protecting policyholders' interests.

To effectively prevent commingling, insurance companies should consider implementing the following best practices:

Segregation of Funds: Insurers should establish separate accounts for policyholders' funds and company assets. This segregation ensures that policyholders' premiums and reserves are

kept distinct from the insurer's operational funds.

Robust Accounting systems: Implementing robust accounting systems enables insurers to accurately track and report the movement of funds. These systems should provide clear visibility into the flow of money between different accounts, ensuring transparency and facilitating audits.

Regular Reconciliation: Insurers should conduct regular reconciliations between their financial records and bank statements to identify any discrepancies or irregularities promptly. This practice helps detect potential instances of commingling and allows for timely corrective actions.

Internal Controls: Establishing strong internal controls, such as segregation of duties and dual authorization for financial transactions, helps prevent unauthorized access to policyholders' funds. These controls minimize the risk of intentional or unintentional commingling.

Compliance with Regulatory Requirements: Insurance companies must stay updated with the latest regulatory guidelines regarding fund management and commingling prevention. By complying with these requirements, insurers demonstrate their commitment to maintaining industry standards and protecting policyholders' interests.

For instance, consider an insurance company that adheres to best practices for preventing commingling. They maintain separate accounts for policyholders' funds and company

The Role of Regulators in Detecting and Addressing Commingling Issues

The role of regulators in the insurance industry is crucial when it comes to detecting and addressing commingling issues. Commingling, which refers to the mixing of funds between different accounts or policies, can have serious consequences for both insurers and policyholders. Regulators play a vital role in ensuring that insurers adhere to strict guidelines and regulations to prevent commingling and protect the interests of policyholders.

Monitoring Compliance: Regulators are responsible for monitoring the activities of insurance companies to ensure they comply with established rules and regulations. They conduct regular audits and examinations to assess whether insurers are properly segregating funds and preventing commingling. By closely monitoring compliance, regulators can detect any potential commingling issues early on.

Enforcing Regulations: When regulators identify instances of commingling, they have the authority to take appropriate action against the insurer. This may include imposing fines, sanctions, or even revoking licenses if necessary. By enforcing regulations, regulators send a strong message that commingling will not be tolerated, thereby deterring insurers from engaging in such practices.

Educating Insurers: Regulators also play a role in educating insurers about the risks associated with commingling and the importance of maintaining proper segregation of funds. Through workshops, seminars, and guidelines, regulators provide insurers with valuable insights into best practices for managing funds and avoiding commingling pitfalls. This proactive approach helps prevent commingling issues from arising in the first place.

Collaboration with Industry Stakeholders: Regulators often collaborate with industry stakeholders such as industry associations, consumer advocacy groups, and other regulatory bodies to address commingling issues collectively. This collaboration allows for a comprehensive approach towards detecting and addressing commingling problems within the insurance sector. By working together, regulators can share information, exchange best practices, and develop effective strategies to combat commingling.

Implementing Technology Solutions: In today's digital age, regulators are increasingly leveraging technology to enhance their ability to detect and address commingling issues. advanced data analytics tools can help regulators identify patterns and anomalies in insurers' financial transactions, enabling them to pinpoint potential commingling activities more efficiently. By embracing technology, regulators can stay one step ahead in the fight against commingling.

For example, the Insurance Regulatory Authority of a certain country implemented a centralized database system that allows insurers to report their financial transactions regularly. This system automatically flags any suspicious activities, such as unauthorized transfers between accounts or policies, alerting regulators to potential commingling issues

Future of the Insurance Financial Practices

Safeguarding the future of insurance through responsible financial practices is crucial in order to maintain the stability and integrity of the industry.

Throughout this blog, we have explored the concept of commingling in insurance and its potential consequences. From various perspectives, it is evident that irresponsible financial practices can have far-reaching implications for insurers, policyholders, and the overall market.

Protecting Policyholders: Responsible financial practices are essential for ensuring that policyholders' interests are safeguarded. When insurers commingle funds or engage in risky investment strategies, there is a higher likelihood of financial instability.

This can lead to delays or even denials in claim settlements, leaving policyholders vulnerable and financially burdened. By adhering to responsible financial practices, insurers can prioritize the needs of their policyholders and provide them with the security they expect.

For example, consider a scenario where an insurer commingles premium payments with their own operating funds. If the insurer faces financial difficulties or bankruptcy, policyholders may face significant challenges in recovering their rightful claims. This not only erodes trust in the insurance industry but also leaves individuals without the necessary support during times of crisis.

Maintaining Market Stability: Irresponsible financial practices can have a detrimental impact on the overall stability of the insurance market. When insurers fail to manage their finances responsibly, it can create a ripple effect throughout the industry. This can result in increased premiums for policyholders, reduced competition among insurers, and even systemic risks that threaten the entire market.

For instance, if multiple insurers engage in commingling and subsequently experience financial distress, it could lead to a domino effect where other insurers are forced to bear the burden of their liabilities. This not only disrupts market equilibrium but also poses a systemic risk that could potentially destabilize the entire insurance sector.

Regulatory Oversight: Responsible financial practices are often enforced through regulatory oversight. Regulators play a crucial role in monitoring insurers' financial activities and ensuring compliance with established guidelines. By implementing robust regulatory frameworks, authorities can mitigate the risks associated with commingling and other irresponsible financial practices.

For instance, regulators may require insurers to maintain separate accounts for policyholders' funds, ensuring that these funds are not commingled with the insurer's own assets. Additionally, regulators may impose capital adequacy requirements to ensure insurers have sufficient reserves to meet their obligations. These measures help protect policyholders and promote

responsible financial practices within the insurance industry.

Fiduciary Responsibility

Definition: Fiduciary responsibility in insurance refers to the legal and ethical obligation of insurance professionals to act in the best interests of their clients, exercising care, loyalty, and good faith.

Example: An insurance agent recommends a policy that best suits the client's needs, even if it means earning a lower commission.

What Is Fiduciary Responsibility in Insurance?

Fiduciary duty is a legal and ethical obligation that requires insurance professionals to act in the best interests of their clients. Insurance professionals are expected to exercise a high level of care, loyalty, and good faith in their dealings with clients.

This means they must put the client's interests ahead of their own and avoid any conflicts of interest that could compromise their ability to act in their client's best interests.

Examples of actions that breach fiduciary duty in insurance include recommending insurance products that are inappropriate for the client's needs.

It can also be in the form of failing to disclose material information about insurance products, misrepresenting the terms and conditions of an insurance policy, and mishandling client funds.

Fiduciary Responsibilities of Insurance Professionals

Insurance professionals have several responsibilities when it comes to fulfilling their fiduciary duty to clients. These responsibilities include:

Understanding the Client's Needs and Goals

Insurance professionals must take the time to understand their client's financial and insurance needs and goals. This means asking questions and listening carefully to their clients' responses.

Only by understanding their client's needs can insurance professionals recommend appropriate insurance products.

Providing Accurate and Complete Information About Insurance Products

Insurance professionals must provide their clients with accurate and complete information about insurance products, including the terms and conditions of the policy, the premiums, the deductibles, and any exclusions.

This information must be presented in a way that is clear and easy to understand.

Recommending Products That Meet the Client's Needs

Based on their understanding of the client's needs and goals, insurance professionals must recommend insurance products that are appropriate for the client.

This means selecting products that provide the necessary coverage while being affordable and manageable for the client.

Handling Client Funds With Care and Transparency

This includes providing regular statements and accounting for any fees or commissions earned from the sale of insurance products.

Acting in Good Faith When Dealing With Clients

This means being honest, fair, and transparent in their dealings and avoiding any conflicts of interest that could compromise their ability to act in their client's best interests.

Building Trust and Credibility With Clients

When insurance professionals act in their client's best interests, they establish themselves as trustworthy and reliable partners committed to providing high-quality service.

This can lead to long-term relationships and generate referrals, benefiting the insurance professional's business.

Reducing the Risk of Legal and Financial Liability

When insurance professionals act as fiduciaries, they are less likely to face legal action or financial penalties for misconduct or breach of fiduciary duty. This can help to protect the insurance professional's reputation and financial well-being.

Promoting Transparency and Accountability in the Insurance Industry

By acting in the best interests of their clients, insurance professionals help to create a more transparent and trustworthy insurance market.

This can lead to increased consumer confidence and greater trust in the insurance industry as a whole.

Benefits for Consumers in Working With Fiduciary Insurance Professionals

Consumers who work with fiduciary insurance professionals can benefit in several ways. First, they can enjoy the peace of mind that comes with knowing that their insurance needs are being handled by a professional who is committed to acting in their best interests.

This can help consumers to feel more confident in their insurance coverage and less anxious about potential risks.

Second, fiduciary insurance professionals can help consumers to find the insurance products that are best suited to their needs and goals.

By providing personalized service and advice, fiduciary insurance professionals can help consumers to make informed decisions about their insurance coverage and feel more in control of their financial future.

How to Identify Fiduciary Insurance Professionals

Identifying fiduciary insurance professionals can be challenging, but there are several things consumers can look for when selecting an insurance professional. Here are some tips on identifying fiduciary insurance professionals:

Credentials and Certifications to Look For

One way to identify fiduciary insurance professionals is to look for certain credentials and certifications. For example, Certified Financial Planners (CFPs) must adhere to a fiduciary standard when providing financial advice.

Other certifications indicating a commitment to fiduciary responsibility include the Registered Investment Advisor (RIA) designation and the Accredited Investment Fiduciary (AIF) certification.

Questions to Ask When Selecting an Insurance Professional

Another way to identify fiduciary insurance professionals is to ask potential insurance professionals about their fiduciary responsibilities and how they fulfill them. Consumers can ask questions such as:

Do you act as a fiduciary when providing insurance advice?

How do you ensure you act in my best interests when recommending insurance products?

Can you provide examples of how you have fulfilled your fiduciary responsibilities in the past?

Insurance professionals who are committed to acting as fiduciaries should be able to provide clear and detailed answers to these questions.

Resources for Finding Fiduciary Insurance Professionals

Finally, there are several resources available for consumers who are looking for fiduciary insurance professionals. For example, the National Association of Personal Financial Advisors (NAPFA) provides a directory of fee-only financial advisors who adhere to a fiduciary standard.

Other resources include state insurance departments, which may be able to provide information on insurance professionals who have been disciplined for misconduct or breach of fiduciary duty.

Examples of Best Practices for Fulfilling Fiduciary Responsibilities

To fulfill their fiduciary responsibilities, insurance professionals should follow best practices such as:

Documenting All Communications With Clients

Insurance professionals should keep detailed records of all client communications, including phone calls, emails, and meetings. This can help to prevent misunderstandings and disputes down the road.

Continuing Education

Insurance professionals should stay up-to-date on changes in the insurance industry, including new products and regulations. Continuing education can help insurance professionals to serve their clients better and avoid any missteps.

Regularly Reviewing Insurance Policies

Insurance professionals should review their clients' insurance policies regularly to ensure they are still appropriate for their client's needs and goals.

Changes in the client's life circumstances, such as marriage, divorce, or the birth of a child, may require changes to their insurance coverage.

Final Thoughts

Fiduciary responsibility is an important concept in the insurance industry that all insurance professionals and consumers should understand.

By fulfilling their fiduciary responsibilities, insurance professionals can build trust and credibility with clients, reduce the risk of legal and financial liability, and promote transparency and accountability in the insurance industry.

Consumers who work with fiduciary insurance professionals can benefit from the peace of mind

that comes with knowing that their insurance needs are being handled by a professional who is committed to acting in their best interests.

By following best practices and staying up to date on changes in the insurance industry, insurance brokers can fulfill their fiduciary responsibilities and provide high-quality insurance services to their clients.

Sharing Commissions

Definition: Sharing commissions in insurance involves splitting the commission earned from a policy sale between two or more agents or brokers, typically when one agent refers a client to another.

Example: Agent A refers a client to Agent B, who has a specific expertise. Agent B sells the policy, and they share the commission.

When a licensed agent or agency, which does not have an appointment from a particular insurance company, refers an application for insurance to another agent or managing general agent, who does have an appointment with that company, and the referral has resulted in the issuance of a policy of insurance written by that company, the agent who has the appointment may share the commission with the agent who does not have an appointment.

The agent (without an appointment from the company that takes the risk or issues a policy)

may prepare an application for insurance,

may collect and remit premium due to the agent issuing any such policy, and

may deliver the policy and any endorsements to the insured and shall as to such activities be regarded as the agent of the insured and shall not be considered to be the agent of the company for any purpose.

Upon making such referral, the agent without an appointment from the company that takes the risk shall make written disclosure to the insured that such agent is not authorized to bind coverage or to execute or issue a policy for the subject risk.

An agent without an appointment from a particular insurer may not sign or execute policies or issue binders, endorsements, or any other indication of coverage on behalf of that insurer.

MGA License May Be Required

According to Chapter 4053 of the Texas Insurance Code, an agent who accepts business from other agents is required to obtain a Managing General Agent's license if the agent accepts more than $500,000 in annual premium volume or if the brokered business represents 50% or more of the agent's total business.

References:

RULE §19.905 Referral Business and Insurance Company Appointments - Texas Administrative Code

Additional Fees

Definition: Additional fees in insurance are extra charges that policyholders may incur beyond the regular premium payments. These can include administrative fees, service charges, or fees for additional coverage options.

Example: A policyholder pays an extra fee for adding a rider to their life insurance policy.

What are Insurance fees?

"Insurance Fees" refer to the various charges and costs associated with purchasing and maintaining an insurance policy. These fees can encompass a range of expenses, from initial policy setup charges to administrative costs and premium loads.

Insurance companies levy these fees to cover the costs of underwriting, issuing policies, managing claims, and other operational expenses. The nature and amount of these fees can vary widely based on the type of insurance, the provider, and the specific terms of the policy.

For policyholders, understanding insurance fees is crucial to gauge the true cost of coverage. The most prominent fee is the premium, which is the amount paid regularly (e.g., monthly or annually) to keep the policy active.

Unfair Claims Practices

Definition: Unfair claims practices involve improper actions by insurers to avoid, delay, or reduce the size of a claim that is due to be paid out to an insured party. These practices are illegal and regulated by state laws.

Example: An insurance company delays processing a legitimate claim to avoid paying out the benefits.

What Is Unfair Claims Practice?

Unfair claims practice is the improper avoidance of a claim by an insurer or an attempt to reduce the size of the claim. By engaging in unfair claims practices, an insurer tries to reduce its costs. However, this is illegal in many jurisdictions.

Key Takeaways

An unfair claims practice is what happens when an insurer tries to delay, avoid, or reduce the size of a claim that is due to be paid out to an insured party.

Insurers that do this are trying to reduce costs or delay payments to insured parties and are often engaging in practices that are illegal.

Many states have passed unfair claims practices laws to protect insured parties from bad behavior on the part of insurers in the claims settlement process.

Unfair Claims Settlement Practices Acts (UCSPA) are enforced by individual states, rather than the federal government, and vary state-by- state.

Understanding Unfair Claims Practice

The National Association of Insurance Commissioners (NAIC) has created a model of unfair claims practice legislation that mandates claims be handled fairly and that there be clear communication between the insurer and the insured.

States, not the federal government, regulate insurance; many jurisdictions have implemented unfair claims practices laws modeled after the NAIC's model act.

Also, most states have enacted a version of this model law. Called the Unfair Claims Settlement Practices Act, it protects insurance buyers from unjust behavior by insurers in the claims settlement process. Specifics of the law vary from state to state.

Unfair Claims Settlement Practices Acts (UCSPA) are not federal law; instead, they are enforced by individual state insurance departments.

Example of Unfair Claims Practice

Consider a small business owner that insures his company's building and business personal property under a commercial property policy.

Unfortunately, a fire broke out in the building, causing $100,000 in property damage. The insurance company delays payment, rendering the business owner unable to repair any of the damage. The insurance company continues using delay tactics to avoid making a payment. For example, the claims representative keeps "forgetting" to send the claim forms. Also, the adjuster says he needs another proof of loss, but the small business owner has already submitted proof of loss twice. These are the types of situations that unfair claims practice laws are designed to prevent.

Other Examples of Unfair Claims Practice

Misrepresenting relevant facts or policy provisions. For instance, your commercial property policy states that Building Ordinance coverage is included, but your insurer insists the coverage is excluded.

Making a significant alteration in an application without your consent and then settling a claim based on the alteration. For instance, in your application, you requested a $50,000 limit for Utility Interruption coverage, but your insurer reduced the limit to $10,000 without telling you. The insurer then refuses to pay more than $10,000 for a loss.

Settling claims for less than what you would reasonably expect based on a written advertisement you received. For instance, an ad announces a

$50,000 limit for damage caused by flooding. However, the ad doesn't mention anywhere that this coverage is provided only if the insured pays an additional premium beyond the premium stated in the ad.

Fraud

Definition: Insurance fraud is any deceptive act performed with the intent to obtain an improper payment from an insurance company. This can include submitting false claims or exaggerating damages.

Example: A person stages a car accident to claim insurance money for non- existent injuries.

What Is an Insurance Fraud?

Insurance fraud is any deceptive statements, behaviors or actions made in connection with the purchase or sale of an insurance policy or made in connection with the insurance policy claims process.

Insurance fraud is an intent crime. You must purposefully engage in deception in order to be guilty. You must also commit a fraudulent act, such as submitting a false claim to an insurer.

In general, it doesn’t matter if your fraud was successful, causing anyone to lose money or causing you to receive any benefits as a result of the dishonesty. It’s enough to intentionally engage in a fraudulent action in relation to insurance.

Legal Definition of Insurance Fraud

“Insurance fraud” is a broad term that encompasses behaviors including the embezzlement of insurance premiums and burning down a house to collect the insurance money.

Both state and federal governments have statutes in place that prohibit various types of insurance fraud. What is insurance fraud under these state laws and federal law? Here are some examples:

18 U.S. Code Section 1033 prohibits those in the insurance business whose activities impact interstate commerce from intentionally making false or material statements related to financial reports or documents presented to an agency regulating the insurance industry.

Title 18 Section 4117 of the Pennsylvania Crimes Code prohibits, among other things, acting with the intent to defraud or presenting an insurer with a statement supporting a claim that contains false, incomplete or material information related to the claim.

California Penal Code Section 550 PC makes it unlawful, among other things, to knowingly present false or fraudulent claims to collect an insurance payment; to present multiple claims for the same loss with intent to defraud an insurer; to stage a motor vehicle accident or theft in order to make a fraudulent insurance claim or to conceal information relevant to insurance eligibility.

These are just some of the many different statutes that make insurance fraud crimes illegal. While there are important differences in the insurance fraud definition from place to place, the legal elements of an insurance fraud offense typically include:

acting intentionally to commit fraud

making false or misleading statements

the fraudulent or misleading statements are made in connection with the purchase, sale or use of an insurance policy

Types of Insurance Frauds

There are many different kinds of fraudulent misconduct that you could be charged with. Some examples of insurance fraud that could lead to an indictment include the following:

staging an accident or a theft to make a false insurance claim

inflating the amount of property damage when making an insurance claim

healthcare providers billing for services that are not provided or billing for the wrong services

faking a death or disability to collect life insurance

agents stealing insurance premiums

unlicensed or unauthorized sales of fraudulent insurance products

“churning,” or agents presenting false or misleading information to consumers to prompt them to buy expensive and unnecessary insurance products

Insurance fraud can occur in connection with all different types of insurance policies including:

health insurance

life insurance

homeowners or renter’s insurance

auto insurance

workers’ comp insurance coverage **How To Report Insurance Fraud** Insurance fraud can be reported to:

the insurance company that is being defrauded

your state’s fraud bureau, attorney general or department of insurance

the National Insurance Crime Bureau, a nonprofit organization that can be reached at (800) 835-6422

the National Association of Insurance Commissioners

your local FBI field office

Who Commits Insurance Fraud?

Many people have the potential to commit insurance fraud including:

healthcare providers who overbill or bill for services not performed

property owners or vehicle owners who stage a theft or an accident to make an insurance claim

property owners who burn down a property or vandalize it to make an insurance claim

property owners who exaggerate their injuries or the extent of their damage after a legitimate incident

employees who fake an injury or exaggerate the severity of their injury to receive more workers' compensation benefits

scammers who sell fake insurance policies or who redirect premiums to themselves instead of to the insurer

fraudulent advisors who engage in "churning," or convincing clients to purchase costly and unnecessary insurance coverage

individuals who lie on an application to obtain insurance

policyholders who fake death or disability to inappropriately obtain a life insurance death benefit

Legal Defenses Against Insurance Fraud Charges

If you are accused of insurance fraud, you can fight the charges against you. A criminal defense lawyer can help you to understand your options for defending your case. Here are some potential defenses you could raise.

Lack of Intent

Insurance fraud is an intent crime. You can be convicted only if you purposefully engaged in fraudulent or misleading behavior. For example, if a doctor simply just made a mistake and accidentally billed the wrong patient's insurance for a service, this would not be an example of insurance fraud, even though they did submit a claim for a service they didn't provide.

No Fraud Occurred

There also must be deception or dishonesty in order for you to be convicted of insurance fraud. If you can show you were actually entitled to the benefit you were trying to claim, then you should be acquitted of insurance fraud charges.

Insufficient Evidence

Prosecutors must meet their legal burden of proof to secure a conviction against you. If they cannot prove beyond a reasonable doubt that you committed insurance fraud, then you can't be found guilty.

You can argue their evidence is insufficient or can aim to have evidence suppressed if it was collected in violation of your Miranda rights or any of your constitutional rights.

Punishments for Insurance Fraud

Insurance fraud can be classified as a felony offense or as a misdemeanor. When comparing felonies vs. misdemeanor offenses, felonies are much more serious crimes.

The potential insurance fraud penalty varies depending on the specific offense you were charged with and your location. Here are some potential examples of an insurance fraud punishment you might face:

a lengthy jail sentence

a large fine

required restitution

loss of professional licensure if you committed insurance fraud as a healthcare provider or advisor

Hard vs. Soft Insurance Fraud

Insurance fraud can be broadly divided into two categories:

Hard insurance fraud. This occurs when you intentionally damage or destroy insured property to make a claim.

Soft insurance fraud. This occurs when you lie to an insurer, either to obtain insurance or to obtain a benefit you don't deserve.

Both hard and soft insurance fraud can result in serious penalties. Many people are incarcerated throughout the United States as a result of dishonesty in relation to insurance transactions. If you are accused of a fraud offense, you should act swiftly to secure legal assistance.