Section 3 – Insurance as a Business of Contracts

Insurance is a business of contracts. However, the insurance contract is different from common business contracts.

One difference is that insurance contracts are not between equals because the insurer has much more control over how the insurance contract is written. Courts routinely award coverage to consumers who believe that they purchased a contract that would cover the loss they suffered.

In this lesson, we'll learn more about the "adhesion" principle described above, and other aspects of the insurance contract.

Learning Objectives

1. Define the terms of contract that apply to insurance.

Section 3 Topic A – Terms of Contract That Apply to Insurance Contracts

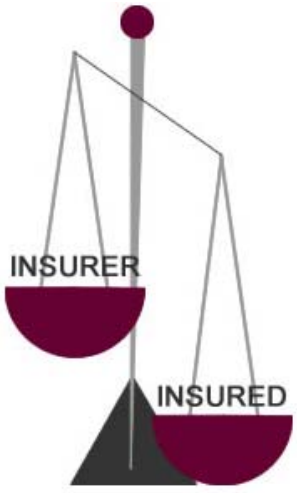
Insurance is a business of contracts—written policies and oral agreements that represent written policies. Contracts are subject to interpretation and if disagreements occur, a court can be asked to interpret the contract. Within this context, there are many legal terms that apply to insurance contracts that do not always apply to other contracts. These terms include:

1. Adhesion
2. Aleatory Contract
3. Personal Contract
4. Unilateral Contract
5. Conditional Contract
6. Binder
7. Reasonable Expectation
8. Indemnity
9. Utmost Good Faith
10. Representations and Warranties
11. Concealment and Fraud
12. Waiver and Estoppel

Learning Objective: Define the terms of contract that apply to insurance.

Contract of Adhesion

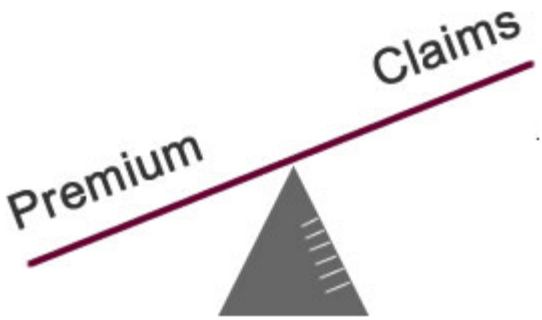
The prospective insured has little to say in the insurance contract's provisions and conditions. Most policies are sold "as is" on pre-printed forms. The buyer's choice is between not purchasing the insurance or buying and adhering to the insurer's provisions.



Because of this one-sided nature of insurance, when a contract ambiguity exists, courts will usually rule in favor of the insured. Courts reason that only the insurance company had the opportunity to make the contract provisions clear when it wrote the insurance contract, and if it fails to do so, then any ambiguity should be interpreted in favor of the insured.

Aleatory Contract

In an aleatory contract there is an unequal exchange between the parties. Insurance is an aleatory contract because the element of chance is involved in the performance of the contract. It is unlikely that the premium in a single insurance contract will be equal to the actual losses paid by the insurance company.



Example
The insured may pay $800 for personal auto insurance and during the policy year have no losses. Another insured may pay $800 in premium for the same coverage but be negligent in a serious accident for which the insurer will pay $30,000. In both events there is an unequal exchange.

Personal Contract

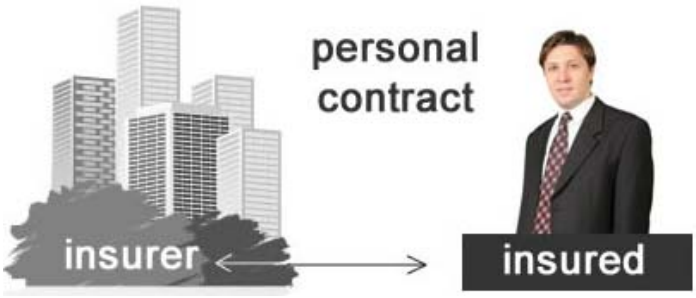
A personal contract in insurance is between the insurer and insured. The property-casualty insurance contract is not property that can be given away or transferred to someone else. The underwriter is not insuring the building, but the business that owns and manages the property. The underwriter does not insure the product for products liability, but the businesses managers who control the design, manufacture and distribution of the product.

If management control changes, the insurance company reserves the right to underwrite the new management.

The insured cannot assign the policy to another without first obtaining written permission of the insurer. In life insurance, the policy owner can transfer certain rights.

The policy owner may or may not be the insured. The owner may change beneficiaries unless the beneficiary designation has been made irrevocable.

What the life insurance policy owner cannot do is transfer the coverage on the life of one person to the life of another.



Unilateral Contract

Unilateral means one way. For the consideration of premium, only one of the contracting parties (the insurer) is required to pay covered losses.

In a bilateral contract, both parties are expected to perform, for example widgets are produced by A for B who is required to purchase a certain amount. Either party in a bilateral contract may require performance of the contract should the other party renege or not meet performance expectations. In a unilateral contract, performance of the insured is payment of premium and the compliance with certain contract conditions before and after a loss.



Conditional Contract

The insurer's promise to pay is contingent upon certain things occurring:

- an event that triggers a covered loss, and
- compliance with policy conditions.

An event that triggers a covered loss:

In property and casualty insurance coverage, for example, coverage is activated by an occurrence that causes a covered loss to the insured or a covered loss to a third party that the insured is legally liable to pay.

Compliance with contract conditions:

The insured may be required to comply with certain elements of the contract. Non-compliance with these conditions and others may void coverage. Some examples include:

- Prompt reporting of the loss
- Cooperation with the insurer in any claim
- Participate in and do not jeopardize any defense the insurer has mounted
- Provide property for inspection

Binders

A binder is a temporary insurance contract. Binders can be written or oral and are usually issued for periods of 30 days or less (unless otherwise governed by contract, insurer guidelines or statute). Oral binders are typically converted to writing as quickly as possible.

Binders do not contain the full contract language of the final policy and as such can be subject to interpretation if a claim occurs prior to policy issuance. Improperly worded binders can grant greater or less coverage than agreed upon by the insured or the insurer.

No "binders" in life insurance contracts:

- The agent does not typically bind life insurance; hence, there is no life binder. The agent submits the life insurance application with the first mode of premium to the insurer.

- Many insurers have a "temporary agreement" or "conditional receipt" on their application.

- With a temporary agreement or conditional receipt, if the applicant should die prior to the issuance of a policy and that insurer would have otherwise issued the policy but for the untimely death, then the insurer may be liable to pay a death benefit up to a maximum amount specified on the application.

- If the person does not die, the life insurance policy becomes effective at the time of acceptance by the company as applied for (no changes).

- If the underwriter makes changes to the coverage offered, the underwriter is making a new offer and the policy does not become effective until the applicant signs appropriate riders or accepts in writing the change in premium or other condition and pays any additional premium required.



An agent in your office issues a binder for liability insurance to a new client. The agent listed the endorsement numbers but not the edition date of the endorsement. A claim occurs. The insurer wants to know which edition date applies. You question the agent, and he says the most recent date, but upon further questioning you discover he is not aware that this particular claim is only covered by the older version of the endorsement. The insurer is in the habit of issuing the newer version of the endorsement but will issue the older version when asked. What should you do?

Advisory Response

First, send the producer to a class or train the producer on the insurance coverage and required endorsements.

You do have a complex ethical decision to make. You could simply say—the older version of the form applies. However, if something should happen to the claim and the claim goes to court, you could put the producer in a difficult position —should I perjure myself and lie about the form edition I chose, or tell the truth and deal with an expensive errors and omissions loss.

You could also explain the problem to the underwriter and ask for the binder to be reformed to list the older version of the endorsement, if the underwriter refuses, call your errors and omissions carrier. The insurer may need to update its underwriting manual to reflect its stance on when the old and broader version of the endorsement can be used so that there is no confusion.

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Knowledge Check

Mary has a personal auto policy with your agency. Her policy is a standard policy with exclusions. **When considering the insurer's promise to pay is contingent upon Mary's compliance with all policy conditions, the policy is would be described as what type of contract?**

a. Contract of Adhesion
b. Personal Contract
c. Unilateral Contract
d. Conditional Contract

The answer is "Conditional Contract".

Reasonable Expectation

People don't often read their insurance policies and if they do many not understand what they are reading.

The doctrine of reasonable expectations means that a court will ask what a reasonable person would expect in this particular situation.

Cases involving reasonable expectations are often complex and the doctrine has not always been consistently applied. However, there are specific court cases where the reasonable expectation doctrine has been successfully applied.

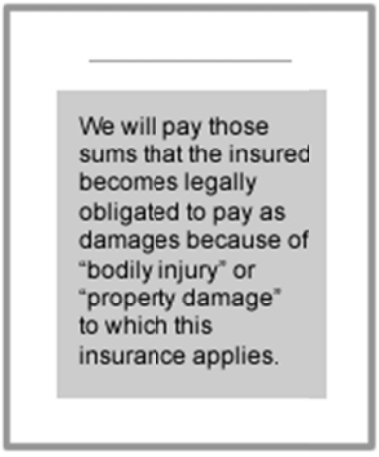
MAX TRUE PLASTERING COMPANY, Plaintiff v. UNITED STATES FIDELITY AND GUARANTY COMPANY, Defendant

Oklahoma Supreme Court. No. 85,860. February 27, 1996. In this case, the Plaintiff discovered that some of his employees had established a side business that had taken business from his own. He filed a claim under his employee dishonesty policy. The insurer denied the claim on a number of grounds including that the policy only covered losses to money and securities and property other than money and securities.

The insurer argued that this loss was to intellectual property and not covered by the policy.

The plaintiff countered that the policy language was ambiguous and that the plaintiff could reasonably expect such a claim to be covered by an “employee dishonesty policy”. The court agreed with the plaintiff. In adopting the reasonable expectations argument, the court said, "… under Oklahoma law, the reasonable expectations doctrine may be applied in the construction of insurance contracts and that the doctrine may apply to ambiguous contract language or to exclusions which are masked by technical or obscure language or which are hidden in a policy's provisions …"

Indemnity



Property-casualty insurance contracts, with few exceptions, are contracts of indemnity. The principle of indemnity is to compensate or reimburse. The concept of profit is not part of the principle of indemnity. When a loss occurs, the objective in most policies is to make the insured “whole,” subject to agreed upon deductibles or retentions.

Indemnity does not have to mean “put the person back into the identical financial position as before.” Many factors such as inadequate insurance or noncompliance with insurance-to-value policy provisions may not make the insured whole after a claim. In life insurance, there never seems to be enough benefit to support the beneficiaries.

Utmost Good Faith

Insurance contracts are said to be a contract of utmost good faith, because each party to the contract (the insurance company and insured) must rely heavily on the integrity and honesty of each other. The insurance company relies upon the accuracy of the applicant's statements. The insured relies upon the company's promise to pay future claims.

The agent is intertwined with both parties in the contract. The agent owes the insurer the utmost good faith that he/she has not withheld pertinent or relevant information. The agent owes the insured the duty to place insurance, priced in the best interest of the insured, with a financially sound insurer.

Consumers want the cheapest price. They also want value. It is the responsibility of the agent to match the best value at the best price for the customer. Agents often compare one coverage quotation with another with an insured. It is then the insured's responsibility to choose whether to take the cheaper policy that covers less, or the more expensive policy that covers more.

Representations, Misrepresentations and Warranties

Representations and Misrepresentations

Representations are oral or written statements of facts made by an applicant for insurance.

A representation is not part of the property casualty insurance contract.

Underwriters use this information supplied by the applicant in their decision to write policies.

Information that is fundamental to the issuance of the policy if misrepresented by the applicant can void the policy. Many policies have clauses that state that "material misrepresentations" of fact can void coverage.

Joe represents on an application that his home is twenty-seven years old when it actually is twenty-six years old. There is an electrical fire.

While this is a misrepresentation, it probably would not be material to the underwriter and the policy would not be voided because of this fact.

Joe also represented that the aluminum wiring that was present in the home at the time of construction was replaced with copper wire ten years ago.

In fact, the old wiring did exist and was the proximate cause of the fire.

If the change in wiring was fundamental to the underwriter's decision to write the account, the policy may be voided and the claim not paid.

Warranties

Warranties are statements that promises or guarantees that something is absolutely true or will be true in the future. For a statement to be considered a warranty, it must be made part of the policy. In many Directors and Officers policies, the application and its warranty statements of known wrongful acts or conditions that may lead to wrongful acts is made part of the policy and if any warranted statement is found to be false, the policy is void.

Warranties are most often found in equipment breakdown, aviation, watercraft and directors and officers coverage. Warranties are not common in other property-casualty insurance contracts.

Note: the application and its representations become part of the life insurance policy. Statements in a life insurance application are representations, not warranties.



The Very Big Business Group is negotiating to purchase D&O coverage. In the application, the Chairman, President and CFO must warrant that their statement of known losses, known wrongful acts and circumstances that may lead to wrongful acts are true and complete. Very Big Business Group has an activist shareholder group that sues the company officers for incompetence and fraudulent withholding of information every time the company does not meet analyst earnings expectations. The CFO confides to the agent that preliminary indications are that the company may at the end of the quarter be one cent short to one cent greater than analyst earnings expectations. He says that he does not want to make this information public because the difference depends upon as yet confidential contract negotiations with a major buyer whose bid deadline is within the quarter.

He asks whether he should put this down as circumstances that may lead to a wrongful act claim. How would you respond?

Don't put it down. The CFO doesn't know enough to judge the situation at this time. Besides, the account already suffers from claims from this activist shareholder group and the underwriter may decline the account.

Tell the incumbent D&O carrier about the situation, they will cover anyway—give the incumbent carrier every possible situation you can think of. Don't put it on the new application.

Report the situation to the incumbent carrier and list on the application for the new carrier. We don't have enough information about how the policies are constructed to determine which carrier will be responsible for paying the loss.

Advisory Response

It may be prudent to ask the underwriter for a determination and to document that decision so that if there is a claim, the intent of the insurer at the time of the application is in writing, if the insured changes carriers, it may have to report the situation within the policy period to the expiring carrier to be entitled to a defense if the situation turns into a claim.

The insurer may need to provide a clearer explanation or definition in the application of which incidents or potential wrongful acts are required to be listed.

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Concealment and Fraud

A fraudulent insurance act is defined as an act committed by anyone who, knowingly and with intent, defrauds another person for gain.

There are three elements required for fraud to exist:

1. There must be a manipulation of the truth
2. There must be intent to get someone to rely upon the manipulation
3. The result of the manipulation is detrimental to someone.

Fraud can occur at the time of the application, at the time a claim is made or during the process of filing and negotiating a claim's payment. Fraud is illegal in all states and will void an insurance contract.



Mike is a good customer who has commercial lines, personal lines and a large amount of life insurance with the agency. Mike has always been an aggressive businessperson, who lives well, even above his means at times. Mike's home burned, damaging his upstairs bedroom suite and part of the downstairs. Mike is single, lives alone, and has no steady girlfriend, yet he claims twenty-seven pairs of designer women's jeans for a total of nearly $2,700 dollars as part of his inventory of damaged goods. The adjuster is suspicious of this number and has asked the agent whether these values are consistent with Mike's lifestyle, if you were the agent, how would you respond?

Call Mike to clarify and if not true, ask Mike to revise his inventory? What if he won't? What happens then?

Just tell the adjuster that this is consistent with Mike's lifestyle, even though you are not sure about the jeans?

Tell the adjuster you don't know and that he should investigate further?

Advisory Response

If Mike is padding the claim, it's fraud. Call Mike and find out what the real story is. It may be innocent—"My sister's stuff". If you don't get a good answer the responsible agent will tactfully inform Mike that padding a claim is fraud and punishable by fines and/or jail time, if Mike is committing fraud here, what other things is he doing in his business that will give you even more headaches?

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Waiver and Estoppel

A **waiver** is a voluntary giving up of a known right. **Estoppel** is the removal of a right or claimed position by acting in a manner that is inconsistent with that right or position.

Reservation of Rights

In most property and casualty insurance policies, insurers have the right and duty to defend the insured for covered causes of loss even if the allegations may not be true.

Casualty insurance policies will not defend claims that are clearly not covered by the contract.

However, early in the claims process, it may be difficult for the claims adjuster to determine whether the circumstances surrounding the loss are covered or not.

Insurance company adjusters often send the insured a “reservations of rights letter” which says that the company is investigating the facts now but reserves the right to deny the claim at a later date.
If the company does not send this letter, it may be estopped from denying the claim in the future, because it gave the insured the impression by its investigatory actions that the claim was being covered.

The company could deny a gray area claim entirely; however, if the claim was later found to be a covered claim, the insured could initiate a bad faith lawsuit and claim punitive damages over and above the amount of the covered claim.

Bad Faith

Bad faith claims against insurers are becoming more common and are often filed when:

1. Insurers deny coverage in a first-party claim and the insured later prevails in court, or:
2. The insurer takes too long to offer any settlement (delaying tactics), or;
3. The insurer otherwise does not treat the insured fairly in the process of settling the claim.

"Bad faith" on part of insurer is any frivolous or unfounded refusal to pay proceeds of a policy; it is not necessary that such refusal be fraudulent. For purposes of an action against an insurer for failure to pay a claim, such conduct imports a dishonest purpose and means a breach of a known duty (i.e. good faith and fair dealing), through some motive of self-interest or ill will; mere negligence or bad judgement is not bad faith."

–Black's Law Dictionary 139 (6th ed. 1990)



The XYZ insurance company has great prices for low-value homeowners, but their application has many more underwriting questions than other companies and their contract is more restrictive. At the time of claim, company adjusters routinely look for increases in hazard like brush near the home, more than 1 gallon of gasoline in the garage and large workshops that could be businesses operated out of the home. Invariably, the adjuster will suggest to the claimant that the small offer the company is making is better than what the claimant would get if the adjuster reported the unreported increase in hazard to the "head office". These are unsophisticated, low-income consumers who see the offer as subsistence money that will last for a few months at least. Most accept the offer. Those that don't accept the offer, the adjusters begin the process of trying to void the policy for willful increase in hazard.

Advisory Response

Get this company out of your office. Find another insurer to write the coverage if you can and rewrite all who are with XYZ with that other insurer. If you can't, suggest that these customers go to another agency. The insurer is ripe for bad faith claims and I
for violating the unfair business practices laws of the state. You as the agent will stand with the company in court for having recommended the company to the customer.

The unfair claims settlement practices noted here may be the result of a rogue claims adjuster or the result of local management decisions or actions that are not usual to the operations of the insurer, insurers that have regular audits of claims practices, and claims settlements, can often find these rouge actors and change what could develop into a serious bad faith class action problem.

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Complete the Knowledge Check on Section 3 Terms of Contract p24

Be sure to complete Self Quiz 3 at the end of Section 3.