ICRBR Releases Circular on Worker’s Comp Legislation

The Indiana Compensation Rating Bureau released Circular 2013-05 on July 2 regarding House Enrolled Act 1320, the landmark worker’s compensation legislation that passed during the 2013 Indiana General Assembly. This Circular provides more information on specific provisions contained in the bill, including the implementation of the medical fee schedule and benefit increases, as well as an analysis of the potential impact of the legislation on the worker’s compensation marketplace in Indiana. Please see the full text of the Circular below. The Big ‘I’ would like to thank the ICRB and Ron Cooper for allowing our association to provide this information to our members.

July 2, 2013
Circular 2013-05
To: ICRB Members

HEA 1320 – Additional Information

House Enrolled Act 1320, (Public Law 275), was signed by Governor Pence on May 11, 2013. In addition to ICRB Circular 2013-04 issued June 19, 2013, this circular provides more information on the workers compensation medical fee schedule and benefit provisions in the bill, as well as a summary of the actuarial analysis of the impact on workers compensation system costs.

Quick Summary
• Medical Fee Schedule - reimbursement at 200% of Medicare, effective July 1, 2014
• Repackaged Drugs - prices limited to average wholesale price, effective July 1, 2013
• Benefit increases phased in over 3 years
• Legislative “interim study committee on insurance” will review:
  - Setting a floor below the 200% of Medicare
  - Reimbursement for hospital employed physicians
  - Clean claims and electronic payment of claims
  - Reimbursement rate of implants not covered by Medicare
  - Establishing an advisory committee to work with the WC Board on future issues
• Impact on WC System Costs - between -2.3% (-$16 million) and -0.7% (-$5 million).

The following paragraphs provide a more in-depth explanation of the bullet items shown above.

Medical Fee Schedule
Effective July 1, 2014, the bill caps hospital reimbursements at 200% of Medicare rates. Or stated another way, the Medicare reimbursement amount plus 100%. Note on terminology: a medical fee schedule may also be referred to as “pecuniary liability” or “reimbursement rate”. The bill also provides that amounts may be negotiated [reference Section 5 of the bill, IC 22-3-3-5.2(b)].
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– James A. Roe, CPCU, ASLI, President

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<table>
<thead>
<tr>
<th>NAME</th>
<th>EXTENSION</th>
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<tbody>
<tr>
<td>Steve Duff, CAE</td>
<td>208</td>
</tr>
<tr>
<td><a href="mailto:duff@bigi.org">duff@bigi.org</a></td>
<td></td>
</tr>
<tr>
<td>Carol Dulle</td>
<td>216</td>
</tr>
<tr>
<td><a href="mailto:dulle@bigi.org">dulle@bigi.org</a></td>
<td></td>
</tr>
<tr>
<td>Linda Gray</td>
<td>213</td>
</tr>
<tr>
<td><a href="mailto:gray@bigi.org">gray@bigi.org</a></td>
<td></td>
</tr>
<tr>
<td>Kelly Lonberger</td>
<td>214</td>
</tr>
<tr>
<td><a href="mailto:lonberger@bigi.org">lonberger@bigi.org</a></td>
<td></td>
</tr>
<tr>
<td>Gwendolyn Mason</td>
<td>210</td>
</tr>
<tr>
<td><a href="mailto:mason@bigi.org">mason@bigi.org</a></td>
<td></td>
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<tr>
<td>Ted Mast</td>
<td>209</td>
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<tr>
<td><a href="mailto:mast@bigi.org">mast@bigi.org</a></td>
<td></td>
</tr>
<tr>
<td>Tracey Moore</td>
<td>202</td>
</tr>
<tr>
<td><a href="mailto:tmoore@bigi.org">tmoore@bigi.org</a></td>
<td></td>
</tr>
<tr>
<td>Nicole Murrell</td>
<td>205</td>
</tr>
<tr>
<td><a href="mailto:murrell@bigi.org">murrell@bigi.org</a></td>
<td></td>
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<tr>
<td>Jen Rochester</td>
<td>211</td>
</tr>
<tr>
<td><a href="mailto:rochester@bigi.org">rochester@bigi.org</a></td>
<td></td>
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<tr>
<td>Steve Urban</td>
<td>201</td>
</tr>
<tr>
<td><a href="mailto:urban@bigi.org">urban@bigi.org</a></td>
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<tr>
<td>Carol Watson</td>
<td>203</td>
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<td><a href="mailto:watson@bigi.org">watson@bigi.org</a></td>
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For advertising information, questions or comments please call: (317)824-3780 or (800)438-4424
Fax: (317)824-3786
www.bigi.org
Email: bigiinfo@bigi.org

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There is a provision on implants in the bill that State Representative Matt Lehman has informed us should have been deleted but was not. Reference Section 5 of the bill, IC 22-3-3-5.2(c): “The payment to a medical service provider for an implant furnished to an employee under IC 22-3-2 through IC 22-3-6 may not exceed the invoice amount plus twenty-five percent (25%).” At issue is that the cost plus 25% provision for implants is different than the 200% of Medicare provision for other products and services.

The legislative “interim study committee on insurance” will review the implants provision before the next session and may recommend a different amount. In the interim, the Workers Compensation Board of Indiana (“WC Board”) issued a guidelines letter dated June 14, 2013 for the fee schedule provisions on implants that are effective July 1, 2013.

Repackaged Legend Drugs
A “repackaged legend drug” means any drug that is repackaged (modified) from the original manufacturer. Effective July 1, 2013, whenever a prescription is filled by a health care provider (except retail and mail-order pharmacies) using repackaged legend drugs, the maximum reimbursement amount is computed using the average wholesale price set by the original manufacturer. If the National Drug Code for a legend drug cannot be determined, then the maximum reimbursement amount is the lowest cost generic for that legend drug [reference Section 3 of the bill, new section IC 22-3-3-4.5].

Benefit Increases
Average Weekly Wages (AWW): The bill increases the maximum weekly wages used in the determination of benefits from $975 to $1,170 (20%) and also increases the maximum aggregate benefit payable from $325,000 to $390,000 (exclusive of medical benefits), phased in over three years beginning July 1, 2014. Here’s a table summarizing the amounts:

<table>
<thead>
<tr>
<th>AWW Benefit Summary Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>07/01/09</td>
</tr>
<tr>
<td>07/01/14</td>
</tr>
<tr>
<td>07/01/15</td>
</tr>
<tr>
<td>07/01/16</td>
</tr>
</tbody>
</table>

Permanent Partial Impairment (PPI): The bill increases the amount payable for permanent partial impairment (in dollars) per degree of impairment by 16-25%, phased in over three years beginning July 1, 2014. Here’s a table summarizing the amounts:

<table>
<thead>
<tr>
<th>PPI Benefit Summary Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degrees</td>
</tr>
<tr>
<td>01-10</td>
</tr>
<tr>
<td>11-35</td>
</tr>
<tr>
<td>36-50</td>
</tr>
<tr>
<td>51-100</td>
</tr>
</tbody>
</table>

Impact on WC System Costs
The actuarial analysis estimates the bill’s overall impact on WC system costs between -2.3% (-$16 million) and -0.7% (-$5 million). Sincerely,
Ronald W. Cooper, CWCP
President

www.bigi.org
Most everyone in the workers compensation arena is familiar with an experience modification. The basic idea of an experience modification is to change the premium rate for employers based upon their actual experience in business. Businesses or employers who’ve recently suffered a high number of losses (frequency), or even just a few very bad losses (severity) probably should, based on their experience, pay more for their workers compensation insurance. Those that have few losses and even fewer bad losses than the norm should pay less.

The experience modification (also known as experience “mod” or even “ex mod”) is expressed as a number. An experience mod of 1.0 is average. Good experience gets expressed as a mod of less than one, while bad experience is reflected in a mod above 1.0.

There’s more to it than that, though. The rating bureaus classify prior losses to further refine the calculation of an experience mod…and that’s where the changes for 2013 and beyond come in.

The Primary/Excess “Split Point”
Every workers compensation loss is divided into two parts: the primary loss and the excess loss. How much goes to each share? That’s known as the “split point,” where the division between primary and excess is made. For two decades, Indiana has had a split point of $5,000, meaning that the first $5,000 of every loss is allocated as a primary loss. Every dollar spent on any one claim over $5,000 was allocated to excess loss.

Why split losses into two? We’re measuring two different things. Primary losses are an indicator of claims frequency but not severity; excess losses are more severe but not as frequent (presumably).

So, rating bureaus have developed the split point to calculate experience mods. The entire primary loss – the whole 100% – is used in calculating the experience mod, but only a discounted part – perhaps as little as 8 to 15 % – of the excess loss is used to calculate those same mods.

The Change
The National Council on Compensation Insurance (NCCI) is raising the “Primary and Excess Split Point” over a three-year transition period. The first phase will take effect on January 1, 2013, when the split point doubles from $5,000 to $10,000.

On January 1, 2014, that number will rise to $13,500. January 1, 2015 will see a change to $15,000. Thereafter, time and inflation will dictate the split point.

But why triple the split point in three years? Claim inflation has nearly tripled since the last split point change twenty years ago; the rating bureaus’ changes are designed to coincide with claim inflation.

While the change is coming for 2013, agents and insureds may start to see changes as soon as late August or early September of this year on renewals for January 1 and thereafter. So, the time to educate and prepare yourself, your insureds and your prospects for the upcoming change in the workers compensation “split point” IS NOW.

How Will it Work?
Below is a table on how the split point change could work. For purposes of this illustration, we’ll assume than an employer had the same three losses to “count” and that the excess losses were discounted using a 10% rate:

<table>
<thead>
<tr>
<th>Claim Amount</th>
<th>Up to the Split Point of $5,000</th>
<th>Above the Split Point of $5,000 (and then discounted at 10%)</th>
<th>Total Claim Value for Experience Mod Purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,000</td>
<td>$3,000</td>
<td>0</td>
<td>$3,000</td>
</tr>
<tr>
<td>$11,000</td>
<td>$5,000</td>
<td>$600</td>
<td>$5,600</td>
</tr>
<tr>
<td>$16,000</td>
<td>$5,000</td>
<td>$1,100</td>
<td>$6,100</td>
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Before Total of All Claims Values for Ex Mod Purposes $14,700

<table>
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<th>Claim Amount</th>
<th>Up to the Split Point of $10,000</th>
<th>Above the Split Point of $10,000 (and then discounted at 10%)</th>
<th>Total Claim Value for Experience Mod Purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,000</td>
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<td>0</td>
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<td>$10,000</td>
<td>$100</td>
<td>$10,100</td>
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<tr>
<td>$16,000</td>
<td>$10,000</td>
<td>$600</td>
<td>$10,600</td>
</tr>
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</table>

After Total of All Claims Values for Ex Mod Purposes $23,700

The $9,000 total claim difference due to the change in the split point will cause a higher experience mod, and therefore a higher workers compensation premium. For the most part, accounts with losses rarely exceeding the existing split point of $5,000 will not be affected by the split point change, while accounts with losses above that $5,000 threshold may see a serious impact.

In fact, it is not beyond the imagination to say that a business’ viability could be challenged by these changes. This is especially possible in Indiana, Virginia and South Carolina where the rates are the lowest in the country and thus subject to the greatest adjustment. For its part, the Indiana Compensation Rating Bureau disagrees, saying, “Under first year of transition (2013 at $10,000 split point), 93% of mods will change less than 10 points.”

What to Watch For – and Prepare Insureds For
Some key items to watch for:
1) Accounts may find themselves moving from a mod of below 1.0 to above 1.0, without having any meaningful change in their losses. This is important because...
2) Some organizations can require that their contractors or subcontractors have an experience mod that is at 1.0 or below to be eligible to do work. Contractors that were once eligible become ineligible without having done anything wrong or having changed the nature of their work or risk. And...
3) Some states have credits much like the one in Illinois, which has a Contractors Credit Program in place. Accounts with mods over 1.00 are not eligible for this credit program, which can have a substantial impact on premium. On a related point...
4) Insureds may be currently with a carrier that uses the experience modification to determine eligibility or rate tier. Accounts may move to an ineligible or higher rated tier, simply by virtue of the split point change.

The IIAI would like to thank Rick Pitts and Kurt Kluempers from Arlington/Roe & Company for their work on researching and preparing this overview.
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Knapp Miller Brown Insurance Services
Matchett & Ward Insurance

McGowan Insurance Group
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Prospective IHCP Transportation Providers Must Obtain a Surety Bond

The Indiana Health Coverage Programs has issued a bulletin outlining the new requirement that certain transportation providers for IHCP must obtain a surety bond. This requirement was contained in House Enrolled Act 559 and was passed during the 2013 session of the Indiana General Assembly. The Indiana Big “I” would like to thank IHCP for permission to reprint the bulletin, the text of which is below.

IHCP bulletin
INDIANA HEALTH COVERAGE PROGRAMS BT201335 JULY 9, 2013

As announced in Indiana Health Coverage Programs (IHCP) Bulletin BT201315, effective July 1, 2013, the IHCP will require a surety bond from entities submitting an application to enroll as a common carrier (for-profit ambulatory or nonambulatory) and/or a taxi transportation provider. The surety bond must be in the amount of at least $50,000 and last a minimum duration of three years.

A copy of the bond must be included with the IHCP provider enrollment application in any of the following situations:

- Newly enrolling transportation provider
- Change of ownership of a currently enrolled transportation provider
- Purchase or transfer of assets of a currently enrolled transportation provider

Exceptions
This requirement does not apply to a transportation provider that meets one of the following exceptions:

- A 501(c)(3) organization
- Owned or controlled by a person that is licensed or certified by the Indiana Professional Licensing Agency (IPLA)
- Owned or controlled by a pharmacy with a permit issued by the Indiana Board of Pharmacy
- Owned or controlled by a hospital licensed by the Indiana State Department of Health (ISDH)
- Granted a waiver of the requirement at the discretion of the Secretary of Family and Social Services Administration

- (FSSA):
  - If transportation services are to be provided in a federal state designated underserved area
  - If it has been determined the provider does not pose a risk of submitting fraudulent or false Medicaid claims

Providers seeking a waiver of the surety bond requirement must submit a written request with their provider enrollment packet. The letter must specify why the request is being made and how the enrolling provider believes they qualify for the waiver. The final decision whether to waive the requirement will be made by the FSSA.

**Note:** If a waiver is requested, the provider's application will not be processed until a decision is made to grant or deny the waiver.

If the waiver is not granted, the provider has 30 days from the date of rejection to submit the required bond.

**How to Obtain**
The required surety bond can be obtained by contacting a licensed insurance broker who will find a company to underwrite the bond. It is important that the broker be given the specific surety bond requirements to ensure that the bond is compliant with the new regulation. The verbiage below outlines the Surety Bond Requirements and can be copied for reference by the insurance broker.

**Questions?**
If you have questions about this information, please contact IHCP Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

**Indiana Medicaid Surety Bond Requirements**

For transportation providers that must have a surety bond to enroll in the Indiana Medicaid program, as specified in Indiana Code 12-15-11-2.5, the bond must meet the following requirements:

- The surety bond must be continuously in effect for at least three years after the provider enrollment application is made.
- The surety bond must provide coverage for liability of at least $50,000.

- The surety bond must name the:
  - Transportation provider as the principal
  - Office (Office of Medicaid Policy and Planning) as the obligee
  - Person that issues the surety bond, including the person’s heirs, executors, administrators, successors, and assignees, jointly and severally, as surety

- The surety bond must provide the surety’s name, street address or post office box number, city, state, and ZIP Code.

- The surety bond must provide that the surety is liable under the surety bond for a duplicate, erroneous, or false Medicaid claim paid by the Office or its fiscal agent to the transportation provider during the term of the surety bond.

- The surety bond must provide that the bond may not be void on a first recovery, but that suits may be instituted until the penalty is exhausted.

- The surety bond must guarantee that the surety will, no later than 30 days after the surety receives written notice from the Office containing sufficient evidence to establish the surety’s liability under the surety bond as described in subdivision (5), pay to the Office the following amounts, not to exceed the full amount of the surety bond:
  - The amount of the duplicate, erroneous, or false claim paid by the Office or its fiscal agent to the transportation provider plus accrued interest
  - An assessment imposed under IC 12-15-22 by the Office on the transportation provider

- The surety bond must provide that if the transportation provider's provider agreement is not renewed or is terminated, the surety bond submitted by the transportation provider remains in effect until the last day of the surety bond coverage period and the surety remains liable for a duplicate, erroneous, or false claim paid by the Office or its fiscal agent to the transportation provider during the term of the surety bond.

- The surety bond must provide that actions under the surety bond may be brought by the Office or by the Office of the Indiana Attorney General.
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Sometimes little things mean a lot. And every day, when something bad happens to someone, West Bend makes sure your customers experience the Silver Lining. Because the worst brings out our best.
HIPAA Omnibus Rule will have Big Impact on “Business Associates”

HHS & Attorney Generals can Impose Fines Directly on “Business Associates” Beginning on September 23, 2013

By the ACT HIPAA Work Group

Note: This article is an educational piece to alert agencies to the requirements of HIPAA, the HITECH ACT and the HIPAA Omnibus Rule and to assist agencies in complying with these laws. It is extremely important for agencies to carefully review the applicable laws and regulations and to decide independently on the appropriate course of action for their firms. If specific advice is desired, the services of an appropriate, competent professional should be sought.

The HIPAA Omnibus Rule goes into effect on September 23, 2013 and promises to bring a much higher degree of enforcement attention on independent agencies and brokerages which are “Business Associates” under HIPAA. HHS is now required to conduct periodic audits of both Covered Entities and Business Associates for compliance with HIPAA, and the state attorney generals are authorized as well to bring HIPAA related actions. Note there is no need for there to have been a breach of Protected Health Information (“PHI”) to trigger such an audit and enforcement action. It is a matter as to whether the Business Associate or Covered Entity has properly implemented the HIPAA compliance requirements.

Who is a Business Associate under HIPAA?

Agencies which sell ANY health insurance products (medical, dental, vision, long term care, Medicare supplements) for companies like Blue Cross/Blue Shield, Humana, Aetna, Principal, Delta Dental, etc. are likely to be Business Associates and their agent agreements will include provisions that require them as Business Associates to comply fully with the HIPAA Security Rule, as well as with the portions of the HIPAA Privacy and Data Breach Rules that are applicable to them.

The 2009 HITECH Act made these HIPAA Rules directly applicable to Business Associates, rather than just via contract with Covered Entities and rendered Business Associates subject to the same civil and criminal penalties and fines that Covered Entities have experienced for failing their audits in recent years.

A “Business Associate” is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a Covered Entity. For it to be PHI, the health information has to include elements that can be used to identify the individual to which the information belongs. “Covered Entities” include health plans, health care clearinghouses and certain types of health providers.

HIPAA does not apply to medical information relating to life insurance, worker’s compensation, auto insurance or other casualty insurance, however, these types of medical information are also highly sensitive and need to be carefully secured by the agency. These other types of medical information are typically protected by other federal and state privacy and data breach notification laws.

Even if an agency is not subject to HIPAA, it will find the resources mentioned in this article to be helpful tools in doing its risk analysis and formulating its security plan and procedures, so that it is compliant with the Gramm-Leach-Billey Act (GLBA) and other federal and state privacy and data breach notification laws with regard to the protected personally identifiable information (“PII”) that it does handle.

Impact of HIPAA Omnibus Rule on Business Associates

The HIPAA Omnibus Rule, effective on September 23, 2013, gives full force and effect to the significant new HIPAA Privacy and Security compliance requirements contained in the 2009 HITECH Act, which amended HIPAA. Here is what the rule means for Business Associates:

- Business Associates are now subject to the same comprehensive Privacy and Security Rule requirements as Covered Entities, as well as to relevant sections of the HIPAA/HITECH Breach Notification Rule. Below we reference an online tool California has developed to assist organizations in complying with the many requirements of the Security Rule.
- HHS and state attorney generals may now impose substantial fines against Business Associates who do not comply with HIPAA/HITECH. Where there is HIPAA “Willful Neglect” = “conscious, intentional failure or reckless indifference to the obligation to comply” – HHS is obligated to investigate violations and the potential penalties become very severe.
- Business Associates are required to execute Business Associate Agreements with any subcontractors which are given access to their PHI. For example, if the Business Associate stores PHI on an online system managed by a vendor, then the Business Associate will need to execute such an agreement with the vendor.

Key Areas of Emphasis for Business Associates

According to Paul Hales, HHS has focused its enforcement actions on covered entities to-date and has cited them for “inadequate or no risk analysis and risk management programs, inadequate or no contingency plans [to protect the PHI in the event of loss or disaster], inadequate and incomplete policies, procedures, documentation and ineffective workforce training.” Note there does not need to be a data breach to trigger an enforcement action; however, if there is a data breach, you can bet that HHS and state attorney generals will be looking at all of these areas.

The HIPAA Omnibus Rule, effective September 23, provides for an expansion of these enforcement actions to Business Associates. HHS’s past actions provide a good roadmap for the kinds of things they will be looking for from Business Associates as well. We recommend that Business Associates:

- Conduct a Risk Analysis, which requires the organization to “conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of electronic protected health information held by the entity.”
- Then implement a HIPAA/HITECH Risk Management Program, which incorporates “security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level.”
- Complete compliance gap assessments to ensure that your Risk Management Program has addressed all applicable sections of the rules. The Security Rule explicitly requires this gap assessment, called an Evaluation (45 CFR §164.308(a) (8)), and its simply good business practice to perform the same type of compliance gap assessment for the Privacy and Breach Notification rules.
- Develop policies and procedures to implement the HIPAA/HITECH Risk Management Program and cover all applicable standards and implementation specifications in the Privacy, Security and Breach Notification rules.
- Train employees on the policies and procedures at least annually and clearly define the disciplinary consequences to employees if they fail to adhere to the agency’s security policies. Maintain accurate records of the training that has been performed.
- Document, document, document, so that you can demonstrate that you have continued on page 10...
HIPAA Feature

HIPAA Omnibus Rule will have Big Impact on “Business Associates” ...continued from page 9

taken all of these steps.
• Execute a Business Associate agreement with any vendor that has access to your PHI by September 23.

Tools to help Business Associates Comply

Hopefully, many agencies will be able to build upon the security plan and procedures that they have already established. In addition, HHS has created the seven part HIPAA Security Series which outlines the administrative, physical and technical safeguards that the HIPAA Security Rule requires, coupled with the requirements relating to the organization, policies and procedures, documentation, conducting a risk analysis and creating a risk management plan. The HHS HIPAA Security Series can be found at www.hhs.gov.

Some Additional Key Areas for Emphasis

As the agency develops its Risk Management Program, here are some important areas to emphasize:
• Identify and document where all the PHI “lives” in your organization — whether paper, electronic or orally communicated.
• Keep the HIPAA Minimum Necessary Requirement of the Privacy Rule in mind, which requires the entity to limit access to PHI to only those employees who need to see the information and to limit disclosure of PHI to the minimum necessary to accomplish the purpose.
• Minimize the amount of Protected Health Information (PHI) that the agency sees or retains to the maximum extent possible. If PHI must be retained in your system, encrypt the data or put it in a password protected PDF. Check with your vendor to see if it is already providing “encrypted data at rest” — which would be a big plus.
• Always use secure email when transporting PHI by email.
• Make sure back ups of PHI are encrypted and kept in a safe and secure place.
• Keep PHI off of laptops, tablets, smart phones, thumb drives, etc. where there is a high risk of loss or theft. Develop and implement your Bring Your Own Device (“BYOD”) policies and procedures which should include your mobile device management plan.
• Regular monitoring of systems and traffic for unusual activity and auditing employees for adherence to the agency’s security procedures are critical to HIPAA compliance.
• Document the process you will follow if there is a breach of PHI in your Risk Management Program, making sure the process complies with the Breach Notification Rule, which requires Business Associates to notify the Covered Entity without unreasonable delay and in any event, no later than within 60 days. Review your agency agreements to see the time period your insurers require for notifying them of breaches – which is likely to be much shorter. The Covered Entity then has obligations to notify the affected individuals, HHS, and the local media (if the breach affects 500 or more people).

This article was produced by ACT’s HIPAA Work Group. ACT (Agents Council for Technology) is a part of the Independent Insurance Agents & Brokers of America, Inc. Please contact Jeff Yates, ACT’s Executive Director at jeff.yates@iiaba.net with questions and comments. ACT’s website is www.iaba.net/act. This article reflects the views of the author and should not be construed as an official statement by ACT.

RELATIONSHIPS

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Throughout the remainder of 2013, IIAI will publish monthly updates of contributors to our state political action committee, IPAC. Over the last month, an additional thirteen corporate and four individual contributions were received by IPAC (the new contributors are listed at the end of each list). To date, IIAI members have contributed $9,355 in personal and corporate contributions to IPAC (an increase of $2,235 in the last month alone, which is outstanding!). This is much appreciated, but frankly, not enough because the 2014 election cycle will be upon us before we know it. If you have not contributed, we need you to do so today!

It is important to note that as of the August IIAI Board of Directors meeting, all Big “I” Executive Committee and Board members have contributed to IPAC. This 100 percent participation illustrates the commitment that the leaders of our association believe in and understand the importance of supporting IPAC.

IPAC supports state legislative candidates who share the same beliefs and philosophies as our members, regardless of party. If you have not contributed to IPAC, the IIAI urges you and members of your staff to go to our website, www.bigi.org, print out a form and send it in. IPAC can receive corporate and/or personal contributions -- and no amount is too small. The IIAI and our industry need your help -- contribute to IPAC today!

And, make sure your name and/or agency's name is on this list next month.

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**AUTO-OWNERS IS A PROUD SUPPORTER OF THE IIAI**

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Compared to decades past, MILLIONS more adult children live with their parents today. An estimated 14% of U.S. family households have at least one adult child living at home. Reports indicate that 65% of recent college graduates had moved back in with their parents. The $64,000 (or more) question is, how are they insured? 

**Q:** “In a Personal Lines Department meeting last week, the subject of “Boomerang Kids” came up. These are kids who are over 18 that have moved back home with their parents, usually following job loss, divorce, etc. Given the state of the economy, the price of gas, and so forth, this is probably not unusual. What are the insurance issues for both parents and kids?”

**A:** “Home is the place where, when you have to go there, they have to take you in.” The great America poet Robert Frost’s immortal line shows that this is an age-old issue. And recent U.S. Census figures illustrate that the trend has increased in recent years.

A study published by the Russell Sage Foundation estimated that approximately 34% of 18 to 34-year-olds were living with their parents. In fact, sociologists have coined the phrase “open nesters,” contrasted with “empty nesters,” as this phenomenon continues to generate more study. Certainly, a number of social and economic factors influence this trend.

Here are some of the insurance issues. For the following discussion, assume Jack and Jill are Mom and Dad, Jillette is their 25-year-old daughter, and Jack, Jr. is their 17-year-old son. Jack is a high school senior, who has always resided with Mom and Dad. Jillette is a college graduate who recently moved back in with Mom and Dad, after living on her own for several years.

**HOMEOWNERS POLICY**

**Insureds.** For Section I Property and Section II Liability & Medical Payments, the definition of “insured” includes anyone who is a “resident relative.” Neither term is defined in the policy. At the time when Jillette moves back in with Jack and Jill, through choice or circumstance, her status as an “insured” in their Homeowners Policy is not clear cut or automatic. In fact, there is a considerable body of jurisprudence dealing with this issue.

For example, if Jill moves in with Jack and Jill for a month or two awaiting the start of a new job, or graduate school, there is some doubt about her residency status. In contrast, if she intends to live with them for the foreseeable future, she would have a stronger argument as to residency. The jurisprudence is replete with endless variations on this issue of when residency exists.

To illustrate how uncertain the term is, consider this excerpt from one court case wrestling with determining residency: “The word ‘resident’ is flexible, elastic, slippery, somewhat ambiguous, obscure, and nebulous in meaning, has many definitions, and is difficult of exact or satisfactory interpretation.”

In situations where there is doubt about Jillette’s residency status, if Jack and Jill’s Homeowners Policy, the safest course of action is for her to procure a policy in her own name – HO-4 in this case. See further discussion below.

**Coverage C – Personal Property.** Jack and Jill’s Coverage C applies to “personal property owned or used by an insured while anywhere in the world.” Thus the personal property of Jack, Jill, and Jack, Jr. is covered worldwide. If Jillette has residency status, her property is likewise covered. If she is not a resident, there is still limited coverage for her property under Jack and Jill’s Coverage C, as follows: After a loss and at your request, we will cover personal property owned by:

- a. Others while the property is on the part of the “residence premises” occupied by an “insured”; or
- b. A guest or a “residence employee”, while the property is in any residence occupied by an “insured”.

As a nonresident, her personal property is covered under their policy only while the property is at their home, or while she is a guest with them someplace else, such as on vacation.

**Coverage C Limitations.** Much of the current literature on “open nesters” indicates that many parents charge their adult kids room and board. Jack and Jill’s Homeowners Policy contains the following limitation: “We do not cover property of roomers, boarders and other tenants, except property of roomers and boarders related to an “insured”.

Luckily for Jillette, even though Jack and Jill charge her room and board, this limitation does not apply to her personal property, since she is a relative. Since Jillette has lived on her own for several years, she will likely have her own household furnishings & contents, TV, and numerous other items of personal property. If she keeps all this property at Jack and Jill’s house, there is the potential that their Coverage C might not be adequate.

Or, Jillette might elect to put much of this property into a storage facility, such as a miniwarehouse. If Jillette has residency status and therefore is an “insured,” there is a provision in Jack and Jill’s policy for certain property off-premises that is subject to a 10% limitation. Here is the excerpt:

---

**Author: Mike Edwards**

Our limit of liability for personal property usually located at an “insured’s” residence, other than the “residence premises”, is 10% of the limit of liability for Coverage C, or $1,000, whichever is greater. However, this limitation does not apply to personal property.

It is important to note that this 10% limitation for Coverage C property which is stored off-premises at a miniwarehouse is NOT subject to the 10% limitation. The limit only applies to personal property which is “usually located at an “insured’s” residence, other than the “residence premises.” The limit only applies when an insured keeps property at another residence of his/hers. The miniwarehouse is not a residence; therefore the 10% limitation does not apply. (NOTE: In the HO 2011 program, ISO added such a limitation for property in a “self-storage facility.”) If Jillette has personal property still at some other residence of hers, then her coverage under Jack and Jill’s policy is 10% of their Coverage C for such property.

If Jillette is not a resident of Jack and Jill’s house, she would have no coverage for her property in the miniwarehouse. As noted above, her coverage as a nonresident would be that afforded to “others while the property is on the part of the residence premises occupied by an insured, or “a guest or a residence employee, while the property is in any residence occupied by an “insured”.

Another personal property issue Jillette needs to address is if she had personal property that should be scheduled, such as jewelry, etc.

**Liability and Medical Payments.** Section II applies to “insureds.” As noted above, Jillette’s status as a resident is not automatic simply because she is staying there. She would have to show more of a residency connection to her parents’ home than merely being there for a short period of time.

**Recommendations.** Probably the safest approach for Jillette is to obtain her own HO-4. As outlined above, her status as an insured depends on her proving residency, so having her own insurance eliminates the problem. Even in cases where she can establish residency for now, at age 25 that is likely to change at some point, probably sooner than later.

Another advantage to her having her own insurance is so that she could secure adequate limits on her personal property, including a schedule for valuable items, or adding coverage for a jet ski, ATV, etc. Also, she could select her own Section II limits, which would be particularly important if she has a Personal Umbrella.
PERSONAL AUTO POLICY

Assume Jillette has her own PAP, and that Jack and Jill have their own PAP.

Issue #1 – Jillette driving Mom's car.
Jack and Jill’s PAP is primary. Jillette is an “insured” in their policy, in one of two ways. In their PAP:

B. “Insured” as used in this Part means:
1. You or any “family member” for the ownership, maintenance or use of any auto or “trailer”.
2. Any person using “your covered auto”.

The PAP contains the following definition of “family member”:

“Family member” means a person related to you by blood, marriage or adoption who is a resident of your household. This includes a ward or foster child.

Therefore, if Jillette is a resident, she is covered by the provisions of B.1., for any auto. If she is not a resident, she is covered as a permissive user under B.2.

In Jillette’s PAP, she is covered in Part A Liability for the “ownership, maintenance or use of any auto or trailer.” Many of the exclusions in Liability are drafted to restrict the broad term “any auto” in order to provide the coverages intended. In Jill’s PAP, the following Exclusion 3 should be reviewed:

3. Any vehicle, other than “your covered auto”, which is:
   a. Owned by any “family member”; or
   b. Furnished or available for the regular use of any “family member”.

   However, this Exclusion (B.3.) does not apply to you while you are maintaining or “occupying” any vehicle which is:
   a. Owned by a “family member”; or
   b. Furnished or available for the regular use of a “family member”.

While her PAP excludes an auto that is owned by a family member, the exception provides coverage for Jillette in her own policy while she is “maintaining or occupying” that car. This would clearly provide coverage for Jillette in her own PAP while she is driving her Mom’s car.

Issue #2: Jack, Jr. driving Jillette’s car.
Jillette’s PAP would be primary, and Jack, Jr. is an insured, either as a “family member” (see “Insured” B.1. above) or a permissive user (B.2.), as discussed in Issue #1.

For excess coverage, Jack, Jr. is NOT covered by Jack and Jill’s PAP, if Jillette is considered a resident family member. Refer to the preceding discussion of Exclusion 3 above. Mom and Dad’s policy excludes liability coverage for an auto “owned by a family member.” The only exception is “while you are maintaining or occupying” the vehicle. In the PAP, “you” is defined as the named insured and resident spouse (i.e., Jack and Jill only).

However, if Jillette is not considered a resident of Jack and Jill’s household, then Exclusion 3 in their PAP would not apply, since the car Jack, Jr. is driving is owned by someone who is not a “family member.” Therefore, in that situation, Jack, Jr. would be still be covered under his Mom and Dad’s PAP for his use of Jillette’s car.

CONCLUSION

When dealing with “Boomerang Kids,” the prudent approach for the agent would be to review the broad spectrum of insurance issues with both the parents and the adult kids. Good documentation would be important.

Another pertinent article is “Who is a Resident Under a Personal Lines Policy.”
Coverage for outages from overhead lines.
Small detail. Big difference.

When the power goes out, your customer’s business goes dark—and they start losing money. With Society, they’re automatically covered for loss of business income even if the outage is caused by storm damage to an overhead power line. After all, that’s how most outages occur. Ironically, other insurance companies see this as reason to exclude losses that result from storm damage to overhead power lines. If you agree that details like these can make a big difference, give us a call at 888-5-SOCIETY or visit societyinsurance.com.
Don’t Get Caught in the Web! (Agency Website E&O Exposures)
Be aware of and mitigate E&O exposures from your website
Sabrena Sally, CPCU Westport Insurance Corporation, Swiss Re

About this article: Agency websites have become a core component of the marketing strategy for many independent agencies, but they also may present errors & omissions exposures that must be managed. This article explores some of the major E&O exposures that may arise and provides several E&O tips for mitigating those risks, as well as sample website disclaimers.

Over 40% of agencies insured through the IIAA-Swiss Re E&O program now have their own website, having grown from 19% in 2006. Having a good website, with robust functionality, has become a core tool for agencies with a modern marketing strategy. Agencies are moving to more complex websites to respond to consumers and clients who increasingly want to shop online and be able to handle basic service needs when convenient for them.

Virtually all agency websites provide basic advertising for the agency, showing the agency name, logo, phone number, address and email link. Over the past eighteen months, however, applications for E&O show a clear trend toward agency websites expanding beyond standard advertising information, as might be expected from expanding consumer online behavior and the services being offered by competitors and other industries.

Advertising Exposure
Let’s first examine what errors and omissions exposures an agency can face from the more traditional type of website. Many of the exposures on these sites are the same that exist in the ‘paper’ world. Advertising liability can arise out of the use or misuse of a trademark, or from the copyrighted material of others, and statements regarding the services available through the agency may be subject to regulatory requirements. At least one state, New York, makes this clear in Circular Letter No. 5 (2001), “Advertisements, Referrals and Solicitations on the Internet,” where it states that “Advertisements that appear on the Internet are subject to all applicable existing statutory and regulatory guidelines and restrictions applicable to advertisements in any other medium.”

E&O Tip: The same level of care in creating ‘paper’ advertising is appropriate for the agency advertising contained on the website. If in doubt, a quick consultation with your qualified legal counsel is well worth the cost.

Websites commonly provide a button allowing a site visitor to contact the agency via email. One could certainly expect questions about what services the agency provides, hours open for business or even driving directions. Keep in mind, however, that there is no way to control what a visitor might choose to include in the content of their email. The visitor might decide to include confidential personal information (such as a name coupled with a social security, drivers license or credit card number) in the unprotected email, creating an exposure to breach of data privacy.

E&O Tip: To help mitigate the liability exposure from this common website feature, posting an appropriate disclaimer is a best practice. A sample disclaimer is provided at the end of this article for agents to use as a starting point and to customize to their agency’s situation.

Posting Website Content
As a simplified case study, let’s view the stages a hypothetical agency might follow in expanding its website over time, and how these changes can affect the agency’s E&O exposure. After constructing a basic website, the next step an agency often takes is to add articles that will be of interest to site visitors. Articles of interest can range widely in subject matter and may be available for viewing only or also as a download. “What is an umbrella policy,” “How to implement an employee wellness plan,” and “Where to find information on OSHA requirements” are examples of topics seen on agency websites. Content can be general in nature or become more technical and specific to certain types of exposures. The options are practically endless.

E&O Tip: If the content is original material created by the agency, practicing due diligence to ensure accuracy of the information is a key preventative measure. The more specific the information provided, the higher the risk of generating allegations against the agency for misrepresentation or providing inaccurate advice.

There is one significant difference between content posted on a website and content published in more traditional forms. Posting content online makes the information available to anyone regardless of their physical location. This instantaneous world-wide availability raises the issue of jurisdiction. It is not yet clear how legal jurisdiction might be applied to content published on a website. Including an appropriate legal disclaimer as part of posted information is for now one’s most effective tool in mitigating the jurisdictional risk.

E&O Tips: If the content is obtained from another source, the first step in risk management is to verify the expertise of the information’s source. This step helps minimize the exposure to allegations of misrepresentation or inaccurate advice. The information is also most likely copyrighted, creating exposure to allegations of copyright infringement. Obtaining written permission from the owner or licensor of the material prior to posting and giving appropriate credit of authorship can help mitigate the copyright exposure. If the content is obtained under a licensing agreement, explore what options may exist to protect the agency via contractual indemnification. As with information authored by the agency, it is recommended that appropriate legal disclaimers be clearly posted with information obtained from other sources.

Website Referrals
As agencies often receive requests from customers for referrals to other service vendors, it is a natural next step for the agency website to include links to these types of service vendors. Windshield repair services, CPAs for tax preparation, and disaster recovery solutions firms, are just a few examples of service vendor links seen on agency websites. Linking to vendors on the agency website can create the same exposure to negligent referral that exists...
when the referral takes place verbally, through email or snail mail. Regardless of how a referral is provided, the best practice recommendation is to provide at least two referrals, leaving it to your customer to choose which vendor to use. If the agency site links directly to a vendor, there also may be exposure to allegations of trademark infringement or unfair use of cyber marks from the vendor.

**E&O Tips:** The best practices to follow to mitigate allegations of negligent referral for vendor referrals, including linking, are to:

1. obtain written permission from the vendor or site to which the link leads
2. provide always more than one selection for each type of service
3. ensure there are appropriate disclaimers regarding the services being provided by these vendors.

**Interactive and Web-based Transactions**

Agencies are increasingly adding interactive website features to increase the effectiveness and efficiency of the agency. When interactive features are included on an agency website, more unique E&O exposures can quickly develop. The most rapidly growing exposure we have seen is the number of agency websites that are accepting application information.

As part of the underwriting process on a recent renewal, we reviewed an agency website. The site opened to a very professionally designed home page. The site had clearly written text, eye-pleasing graphics, was well-organized, and quick-loading. At the bottom of the first page, a link to the agency privacy statement was prominently posted. Following the various tabs, one could easily find informative articles which clearly showed authorship and contained appropriate disclaimer language. So far, so good.

We then clicked on a button titled Personal Lines, on through the Auto Insurance button, to “Submit Application.” The Submit Application button led to a page where a full spectrum of personally identifiable information can be submitted, including: name, address, date of birth, social security number, drivers license number – basically all the information one needs to carry out identity theft. There was no indication of security being enabled by an ‘https’ displayed before the URL (evidence of creation of an SSL connection), and nothing contained within the web page itself referred to secure transmission of this data.

An agency has the duty to protect personally identifiable information and a myriad of both state and federal laws apply. Violations of these laws carry significant financial penalties, not to mention the extreme damage that can be done to the agency’s reputation. One state, for example, specifically requires “encryption of all transmitted records and files containing personal information that will travel across public networks, and encryption of all data containing personal information transmitted wirelessly.” At the most recent count, forty-six states have some type of law or regulation addressing the protection of personal information.

**E&O Tips:** Agencies that collect personally identifiable information (whether on their websites or not) should take the necessary steps to be knowledgeable about state and federal laws and regulations that protect such personal information and provide the level of data security required by them.

A best practice is that the agency website create an SSL connection with the visitor’s browser before the visitor is asked to enter an id or password or any personal information, such as that included on insurance applications, so that this information cannot be read by unintended parties over the Internet.

Many agencies are now expanding their online presence to include social media as a part of their advertising and customer interaction. ACT has an article and webinar on the E&O exposures arising from the use of social media which can be found at www.iiaba.net/act at the “Website & Social Media” link.

**Key activities for mitigating E&O exposures generated by a web presence**

It’s an exciting time as agencies become more creative in using the opportunities that websites can provide. Be creative, but not naive. Keep in mind that with every opportunity, there is risk. Consider the following quick tips to help mitigate your agency’s exposure to errors and omissions that may arise from your agency’s website:

1. Review website advertising with the same level of legal scrutiny toward copyright and trademark issues as the agency’s more traditional advertising.
2. Post an appropriate Privacy Statement prominently on the website.
3. Review original content posted on the website for accuracy and post appropriate disclaimers.
4. Obtain written permission for content obtained from other parties, be confident they are a knowledgeable source, credit their authorship, obtain the author’s indemnification (if feasible) and post appropriate disclaimers.
5. If you decide to refer to other service providers, provide more than one provider name, obtain written permission to link to them and post appropriate disclaimers regarding the services provided by the vendors.

6. If the website has interactive features that collect personally identifiable information, comply with all state and federal privacy and data breach notification laws and regulations and create an SSL connection with the visitor’s browser before the visitor is asked to enter an id or password or any personal information.

**Sample Website Disclaimers**

Agents should consult with their local counsel to customize these sample disclaimers so that they fit their website, are positioned at the appropriate places on the site and comply with all of the federal and state laws and regulations that apply to them. These disclaimers are in addition to the Privacy Statement that the agency should include at the bottom of its website setting out its privacy policies.

**Website Disclaimers**

Please review carefully!

“This information is not an offer to sell insurance. Insurance coverage cannot be bound or changed via submission of this online form/application, e-mail, voice mail or facsimile. No binder, insurance policy, change, addition, and/or deletion to insurance coverage goes into effect unless and until confirmed directly with a licensed agent. Note any proposal of insurance we may present to you will be based upon the
values developed and exposures to loss disclosed to us on this online form/application and/or in communications with us. All coverages are subject to the terms, conditions and exclusions of the actual policy issued. Not all policies or coverages are available in every state.”

“Please contact our office at 555.555.5555 to discuss specific coverage details and your insurance needs. In order to protect your privacy, please do not send us your confidential personal information by unprotected email. Instead, discuss that personal information with us by phone or send by fax.”

“Statements on this website as to policies and coverages and other content provide general information only and we provide no warranty as to their accuracy. Clients should consult with their licensed agent as to how these coverages pertain to their individual situation. Any hypertext links to other sites or vendors are provided as a convenience only. We have no control over those sites or vendors and cannot, therefore, endorse nor guarantee the accuracy of any information provided by those sites or the services provided by those vendors.”

“Information provided on this website does not constitute professional advice. If you have legal, tax or financial planning questions, you need to contact a qualified professional.”

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Sabrena Sally, CPCU is Senior Vice President of Westport Insurance Corporation, a Swiss Re company, and manages the Big “I” Agency Professional Liability Program, which is endorsed by IIABA and 51 Big “I” state associations. Sabrena can be reached at sabrena_sally@swissre.com. Sabrena produced this article for the Agents Council for Technology (ACT), a part of the Independent Insurance Agents & Brokers of America. For more information about ACT, visit www.independentagent.com/act or contact Jeff Yates, ACT Executive Director at jeff.yates@iiaba.net. This article reflects the views of the author and should not be construed as an official statement by ACT or IIABA.
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<td>South Bend</td>
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<td>18</td>
<td>It's Personal: PL Exposures Your Insured Won't Tell You</td>
<td>Terre Haute</td>
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<tr>
<td>19</td>
<td>It's Personal: PL Exposures Your Insured Won’t Tell You</td>
<td>Indianapolis</td>
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## October

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<tr>
<td>1</td>
<td>CL Annual Checkup</td>
<td>Merrillville</td>
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<td>2</td>
<td>CL Annual Checkup</td>
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<td>3</td>
<td>CL Annual Checkup</td>
<td>Terre Haute</td>
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<tr>
<td>8</td>
<td>Recipes for CP &amp; Comm.Casualty Coverages</td>
<td>Fort Wayne</td>
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<td>9</td>
<td>Recipes for CP &amp; Comm.Casualty Coverages</td>
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<td>10</td>
<td>Recipes for CP &amp; Comm.Casualty Coverages</td>
<td>Evansville</td>
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<tr>
<td>16–18</td>
<td>CIC – Commercial Casualty</td>
<td>Indianapolis</td>
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<td>22</td>
<td>Gaps in Personal Lines</td>
<td>Fort Wayne</td>
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<td>23</td>
<td>Gaps in Personal Lines</td>
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<td>24</td>
<td>Gaps in Personal Lines</td>
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<td>29–Nov 1</td>
<td>CRM – Control of Risk</td>
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## November

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<tr>
<td>6</td>
<td>ICRB – Experience Rating</td>
<td>Indianapolis</td>
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<tr>
<td>4-6</td>
<td>IIAI Annual Convention</td>
<td>Indianapolis</td>
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## December

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<tbody>
<tr>
<td>4-6</td>
<td>CIC – Commercial Property</td>
<td>Indianapolis</td>
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<tr>
<td>10</td>
<td>Personal &amp; Advertising Injury</td>
<td>Greenwood</td>
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<tr>
<td>11</td>
<td>Personal &amp; Advertising Injury</td>
<td>Fort Wayne</td>
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<tr>
<td>12</td>
<td>Personal &amp; Advertising Injury</td>
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**“Ask an Expert” Brief**

**Why Should CGL and BAP Coverage be Written with the Same Insurer? CGL-BAP Feature**

**Q:** “Are you aware of any article, white paper, or published court cases regarding the advisability to keep the general liability and auto liability with the same insurer?”

**A:** We’re aware of several actual claims, usually involving loading or unloading or otherwise pertaining to what constitutes “use” of an auto, where different CGL and BAP insurers point at each other as the source of coverage for a claim. Here are two examples of why keeping CGL and BAP policies in the same insurer is usually a good idea (Go to the websites below to view these articles which are password-protected so be prepared to login as a member):


Have you had any claims denied based on loading or unloading with a device that an insurer says is not a “hand truck”? If so, email the details to bill.wilson@iiaba.net.
Bob Knight.
Gary Varvel, Jon Persky, and Rick Pitts.
Steve Anderson and Jerry Rhinehart.

We’ve got big names coming to the convention, but we’re missing the most important person...

You.

www.bigi.org
November 4-6, 2013
The Westin, Indianapolis
Monday, November 4th

10:00 am – 3:00 pm  Agency Perpetuation Workshop (Filed for 4 CE hours) - Presented by Jon Persky, Rick Pitts (with live actors!)
10:00 am – 3:00 pm  Cyber Liability, Social Media & Other Scary New Risk/Rewards (Filed for 4 CE hours)
            - Presented by Steve Anderson
3:00 pm – 5:00 pm  Consumer Agency Portal is Here... Now What?! (Filed for 2 CE hours)
5:00 pm – 5:30 pm  Exhibitor Orientation - Exhibitors & Partners Only
5:30 pm – 7:30 pm  Tradeshow Preview Party - New! A blend of the former “Who’s Who” cocktail reception and the traditional tradeshow. All exhibitors will be present with cocktails and hors d’oeuvres served at multiple stations and bars. Mingle with all your favorites and meet new company and vendor professionals!
7:30 pm  Free time to enjoy downtown Indy’s restaurants

Tuesday, November 5th

7:30 am – 8:15 am  Continental Breakfast
8:15 am – 8:30 am  Welcome and Opening Comments - IIAI President Todd Jackson
8:30 am – 9:30 am  IIAI Keynote Address - Featuring Coaching Legend Bob Knight
9:30 am – 11:30 am  IIAI Tradeshow
11:45 am – 12:45 pm  Agents Roundtable Lunch (Filed for 1 CE hour)
            - Agents-only discussion hosted by the Young Agents of Indiana
1:00 pm – 4:00 pm  National Healthcare Reform (Filed for 3 CE hours) - Presented by Jerry Rhinehart
6:00 pm – 6:45 pm  President’s Reception
7:00 pm – 9:30 pm  Recognition Banquet - Awards & Installation of IIAI Officers

Keynote Speaker
Coaching Legend Bob Knight

Wednesday, November 6th

8:00 am – 9:00 am  Fellowship Breakfast - Featuring Political Cartoonist Gary Varvel
9:00 am – 11:00 am  Issues & Advocacy Forum (Filed for 2 CE hours) - Discussion of legislative and regulatory issues facing the insurance industry - Hosted by the IIAI Government Affairs Committee
IIAI gratefully acknowledges these fine companies, our 2013 Partners. They are generously supporting the annual Big "I" convention and other events held in 2013. Without their assistance, fees for these events would be significantly higher and/or the quality of programming would be restricted.

This is a special program for insurance companies, wholesalers, and vendors who support the Independent Insurance Agents of Indiana on an ongoing basis. For details on how to become an IIAI Partner in 2014, contact Jen Rochester, rochester@bigi.org or (317) 228-3029. Open enrollment begins November 4th during the Big "I" Annual Convention in Indianapolis. Please note: 2014 Partners will be listed by level in the order of their pledge.
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Hold Harmless Agreements Aren’t Harmless

Your insureds routinely sign hold harmless agreements with all kinds of entities... property owners, contractors, large corporations, municipalities, and others. How many of these contracts do you think are covered by your insureds’ CGL policies and to what extent? In this article, we’ll give you a few actual examples that may have you grabbing for the nearest defibrillation machine.

Here’s the scenario: You get a call late Friday afternoon from a client who says, “Hey, I just signed a big, multi-million dollar contract with MegaGlobal Enterprises. It’s got a few insurance requirements in it. I’ll be faxing it over first chance I get just to make sure my insurance covers everything! My crew’s heading out of town to the main job site first thing Monday morning and I’m heading to Rome for a couple of weeks of R&R with the missus. Let me know if you need anything. Ciao!”

Later that night, a fax comes in and is waiting for you on Monday morning. The contract has three pages of insurance (and other) requirements, including the following passage:

To the fullest extent permitted by law, ABC Engineering, Inc. agrees to defend, indemnify and save harmless XYZ Construction, Inc. and Owner, as well as any other parties, which XYZ Construction is required under the Contract Documents to defend, indemnify and hold harmless, and their agents, servants and employees, from and against any claim, cost, expense or liability (including attorneys’ fees), attributable to bodily injury, sickness, disease, or death, or to damage to or destruction of property (including loss of use thereof), caused by, arising out of, resulting from, or occurring in connection with the performance of the work by ABC Engineering, Inc., its subcontractors and suppliers, or their agents, servants, or employees, whether or not caused in part by the active or passive negligence or other fault of a party caused by the sole negligence of a party indemnified hereunder. ABC Engineering Inc.’s obligation hereunder shall not be limited by the provisions of any worker’s compensation or similar act. ABC Engineering, Inc. hereby agrees that One Hundred Dollars and No/ Cents ($100.00) of the Price constitutes the separate consideration for ABC Engineering, Inc. indemnity hereunder. Such amount shall be deemed paid out of the first invoice for payment paid hereunder.

Well, what do you think? Could there be some problems with this hold harmless provision? Wouldn’t you like to get your hands on the guy who drafted this thing? It sounds like it was assembled from passages in a law book drawn at random. Just a few quick points:

“To the fullest extent permitted by law....” Actually, this may be the only positive thing in the provision. At least your insured won’t be held responsible if the other party deals drugs or commits murder (well, we don’t think so).

“...as well as any other parties....” Clearly the other party wants your insured to hold EVERYBODY harmless. In the context of the sentence where this appears, the other party not only wants your insured to hold THEM harmless, the other party wants all other parties named in another document to be held harmless. But it is not clear who those others are or what they will be doing which raises the question of how you will know if the right coverage is in place.

“...and their agents, servants and employees....” No, by “agent,” they aren’t requiring your insured to hold YOU harmless (though that might be a very good idea). An agent is basically anyone you hire to do something for you. Gotta admit, that’s pretty broad.

“...any....” Your insured appears to be holding them (and potentially a few thousand other parties) harmless for ANY claim, cost, expense, liability, etc that can even be remotely attributable to BI or PD. The CGL, for example, covers BI and PD... it does NOT, though, cover ANY thing that arises out of those types of losses. We suppose that, if an injured party was in dire need of a cafè latte, your insured will have to send someone to Starbucks.

“...caused by, arising out of, resulting from....” It is hard to imagine that a clever plaintiff’s lawyer could not fit just about ANY thing into one of these reasons for a claim—it need not even be the direct or a primary reason for the claim—just somehow connected to it.

“...occurring in connection with....” Your insured not only must cover ANY claim arising out of their work, but also anything related to it in presumably any way. It doesn’t get much broader than this, and again, would not take much to find some way to bring most ANY claim under it. This must be one of those “KFC” clauses (Keep your Fingers Crossed).

“...its subcontractors and suppliers, or their agents, servants, or employees....” Not only must your insured hold the other party harmless for work the insured does, they apparently agree to hold the other party harmless for any claims arising out of any work anyone does, including anyone who supplies them with products or services. Needless to say, your insured needs a hold harmless like this with all of their subcontractors, suppliers, etc. Then things will REALLY get interesting when a claim occurs! Gosh, just a minor claim could keep a battalion of lawyers busy for years.

“...or other fault...caused by the sole negligence of a party indemnified hereunder....” This is the Big One, Elizabeth. It looks like your insured has agreed to hold the other party harmless, not only for negligence, but “other fault” (whatever that is, and to a creative plaintiff’s lawyer, it could be anything). Does your insured’s CGL cover “fault”? It gets worse. Not only is your insured holding the other party harmless for claims arising out of your insured’s (and many others’) negligence, your insured will even pay if they do absolutely nothing wrong...they agree to pay even if XYZ Construction is SOLELY negligent...as long as it occurs “in connection with” your insured’s work. Hmm...sounds like your insured is basically providing them with an absolute...no exclusions...liability coverage... for anything. It is a good deal for XYZ Construction...if its sole negligence causes a claim, your insured will pay the freight.

“...shall not be limited by the provisions of any worker’s compensation or similar act....”Oops, there goes the ol’ sole remedy theory.

Do you think there might be problems with this contract? Do you think liabilities might be created that aren’t covered by the insurer’s CGL (or most other policies)? The sad thing is that hundreds or thousands of these types of onerous agreements are signed by business owners every day. For a sobering example of what can happen, check out the article “Subcontractor Must Indemnify General Even When Sub Was Not Negligent.”

Some of them even seek to specifically control the indemnitor’s insurance program. Requiring 30 days notice of cancellation is a common example. Often, the insurer can amend the policy to do that, but rarely with regard to cancellation for nonpayment. Recently, we looked at a hold harmless provision that required that the indemnitee be given 30 days notice if a policy was “materially amended.” The insurer refused to honor this...and rightfully so.

Perhaps more troubling than these types of agreements are circumstances where agents are counseling insureds to join the bandwagon and execute their own hold
harmless agreements with others. Here are two inquiries from agents:

- “We are working with a client and are interested in protecting him to the best of our ability. I was trying to locate an indemnification or hold harmless agreement and a waiver of subrogation that we can give him to use with his subcontractors.”
- “We need a copy of a standard hold harmless agreement that our insured can have his subcontractors sign.” [emphasis added]

It’s doubtful that anything more needs to be said about the above other than: (1) there are no “standard” agreements of this type, and (2) unless you have a license to practice law, don’t do it.

These agreements are not limited to your clients. Agents enter into contracts all the time, both insurance and noninsurance. For example, here’s an excerpt from an actual E&S brokerage agreement:

- AGENT shall indemnify and hold BROKER harmless with respect to all claims, liabilities and costs, including attorney fees, which BROKER may be obligated to pay.

That’s it...period. It doesn’t say anything about the agent’s contractual liability being limited to his/her own negligence. It doesn’t even say that the liability has to relate to business the agent has placed through the broker. The agent is basically agreeing to assume full liability (both general and professional) for even the broker’s sole and unilateral negligence, errors, omissions, and even deliberate or criminal acts of ANY kind!

Do you think your E&O policy would respond when the broker invokes this hold harmless clause? Here’s an example of an E&O policy contractual liability exclusion:

- CONTRACTUAL LIABILITY. Any liability assumed by the insured under contract unless the insured would have been legally liable in the absence of such contract.

Let’s say that an agency producer tells an insured that a certain type of event would be covered. A loss occurs and the insurer rightfully denies the claim. The insured sues the retail agent, E&S broker and insurer. The hold harmless clause above requires the agent to pay on behalf of the broker. The E&O policy provision would respond since the agent is legally liable to the insured anyway. The hold harmless clause doesn’t create the liability...the hold harmless agreement exists in tort law with regard to the insured.

On the other hand, let’s say the broker, during a deposition, physically assaults the plaintiff’s attorney, is sued and is assessed various civil damages and criminal penalties. The hold harmless agreement is so broad that that agent is probably liable under the contract.

In summary, it is important that insureds be advised to have all contracts reviewed by competent legal counsel who can identify the liabilities potentially being assumed. The agent and insurer can then work with the client to determine what liabilities would be covered by existing insurance, what exposures require additional coverages, and what risks cannot be addressed by available insurance products. Then the insured can make an informed decision to renegotiate the contract or implement alternative risk management strategies.

---

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_Todd Jackson, CIC, CWCA
President, Jackson-McCormick Insurance
Lebanon, IN
2013 President, Independent Insurance Agents of Indiana

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To learn more visit www.donegalgroup.com or call Jim Stiegler at 1-800-321-1117.
Personal Lines (Damage to Others Property) Feature

Just Because It’s Not Covered Doesn’t Mean It’s Not Covered

Author: Bill Wilson

The insured’s brother-in-law was helping him clean up some storm damage when a tree limb damaged his lawn tractor. The adjuster denied the damage as a liability claim under the Damage to Property of Others because it requires the damage to be “caused by” an insured. In this case, the adjuster might be right...but that doesn’t mean the damage is not covered.

When determining whether a policy provides coverage for an occurrence, it is critical to review the ENTIRE form. Often we receive “Ask an Expert” questions where the details of the loss are incomplete or we’re emailed proprietary policy excerpts that consist of just a few pages from a policy with a couple of dozen pages. Here’s a recent example:

Q: “My question is about the ‘Damage to Property of Others’ Additional Coverage in the HO 00 03 04 91. It says, ‘We will pay at replacement cost up to $500 per occurrence for property damage to property of others caused by the insured.’ My insured’s brother-in-law was helping clear out some trees that had been damaged due to a windstorm at the insured premises. The brother-in-law’s garden tractor was damaged by a tree limb and the insured presented a claim and was denied as it was not ‘caused by the insured.’ The brother-in-law was driving the tractor at the time of the loss.”

A: You don’t say how the tractor was damaged. In the “Damage to Property of Others” policy provision you cite in the ISO form, it does require the damage to be “caused by” an insured. In addition, it excludes loss arising out of the use of a motor vehicle, the only exception being certain recreational vehicles. Therefore, this additional coverage does not apply to this loss and we can’t otherwise comment on potential liability coverage under Section II since we don’t know what happened and whether the insured could be legally liable. Since the adjuster is citing the “no fault” additional coverage in Section II, presumably this is because s/he feels the insured was not liable for the damage.

However, Section I of the policy says:

**COVERAGE C – Personal Property**

We cover personal property owned or used by an “insured” while it is anywhere in the world. At your request, we will cover personal property owned by others while the property is on the part of the “residence premises” occupied by an “insured”;

It is a common misconception that the policy only covers property owned or rented by the insured. As the highlighted language shows, if the insured chooses to extend coverage, it will apply to the property of others as long as it’s on the part of the premises occupied by an insured.

What about any exclusions pertaining to damage to motor vehicles? Motor vehicles are excluded under Property Not Covered, but the following exception is made:

We do cover vehicles or conveyances not subject to motor vehicle registration which are...Used to service an “insured’s” residence;

Note that, unlike the HO 00 03 10 00 policy, the 1991 form does not require that the vehicle be used solely to service the insured’s premises. So, as long as the cause of loss is covered, the claim should be covered under Section I, less the deductible. But, again, we don’t know the cause of loss because the details of the occurrence are not provided.

In any case, one lesson here is that, just because the insurer correctly cites exclusionary language in one part of the policy, that doesn’t mean that the loss is necessarily excluded if you can find coverage in another part of the policy.

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We get anywhere from 4 - 22 “Ask an Expert” questions DAILY. Some of these Q&A end up as articles in this newsletter or the VU research library, though many waste away on my hard drive. Periodically, when there is a short answer, we try to run these brief Q&As in this section of the newsletter. Here’s the latest installment which is applicable to both personal and commercial lines auto risks:

**Q:** “A pickup truck was pulling a flatbed trailer. Each are covered for physical damage. The insured was rear ended while pulling the trailer with the pickup and both vehicles were damaged. Does the deductible apply per unit (two deductibles) or per occurrence (one deductible)?”

**A:** You do not say whether this is a commercial or personal auto policy nor whether it’s an ISO form or a company form. Coverage questions cannot be answered without knowing the precise language of the coverage form. As a result, we need to know if it’s an ISO form and, if so, what the full form number (including edition date) is. If it’s a non-ISO form, we need a copy of the form. That being said, we’ll assume we’re talking about ISO forms and we’ll answer the question based on both the current ISO BAP and PAP.

This is what the ISO BAP says about deductibles:

For each covered “auto”, our obligation to pay for, repair, return or replace damaged or stolen property will be reduced by the applicable deductible shown in the Declarations. Any Comprehensive Coverage deductible shown in the Declarations does not apply to “loss” caused by fire or lightning.

As the first four words of this deductible provision indicate, the deductible applies per auto. So, in your example, if the policy is an ISO BAP, there would be two deductibles.

This is what the ISO PAP says about deductibles:

We will pay for direct and accidental loss to “your covered auto” or any “non-owned auto”, including their equipment, minus any applicable deductible shown in the Declarations. If loss to more than one “your covered auto” or “non-owned auto” results from the same “collision”, only the highest applicable deductible will apply.

As the second sentence indicates, the deductible applies per accident. So, in your example, if the policy is an ISO PAP, there would be one deductible.

And perhaps the primary learning point of this AAE Q&A is that you can’t answer coverage questions without examining the specific language of the policy in question. For example, a question that begins, “Does ‘an umbrella policy’ cover...” has no answer.
In the May 9th issue of TechTips I suggested that Google+ is a social platform you should embrace. If you missed that issue you can read it here.

There is one more reason your agency needs to embrace Google+ — Google+ Local.

Insurance agencies are, for the most part, local businesses. As a local business, you want to be found and do business with people who live and work within a small radius of your physical office location(s). Forty-three percent of Google search queries are local. Seventy-four percent of these local searches are done using mobile devices.

Google has long provided the ability for local businesses to enhance their Google Maps listing (and thus increase the possibility of showing up in a local search result) by completing their Google Places profile. Google has now replaced the old Places with Google+ Local. You can (and should) also merge your Google+ Local listing with the agency Google+ Business Page.

Benefits of Merging Your Information
Your existing Places listing will still show up in Google searches, but without merging it with your Google+ Page, you’re missing out on the increased SEO benefits and customer engagement.

Merging this information extends your Places information to include directions, reviews, photos, videos, and other Google+ Page features. Google+ Local was designed to be integrated with Google+ Pages so not having them merged means you’re missing out on:

1. Improved search results. Google+ Local sites are grouped at the top of SERPs (search engine results pages).
2. Expanded visuals with Posts, About, Photos, and Videos tabs added.
3. Direct interaction with customers by sharing links, posts, and videos.
4. Freeing up time by being able to assign multiple people to your Google+ Local Page so they can manage your Business Location data from there.
5. Being able to have multiple Pages for multiple branches or departments (commercial lines, personal lines).
6. Friend recommendations showing up in searches. Any searches made in Google Search, on Google+ Local, or in Google Maps will feature results from that user’s Google+ Circle connections.

Things to keep in mind
You will be able to merge your Google+ Local and Google+ Business Page if the category you selected when you set it up is “Local Business or Place.” If you’re listed as a “product or brand,” “company, institution or organization,” “arts, entertainment, or sports,” or “other,” your listing will still appear on a Google+ page but won’t be able to be verified, meaning you won’t have the social networking enhancements.

Note: Your business classification relates to how you set up your Google+ Business Page and not how your Google+ Local Listing is set up.

Your Next Steps
1. If you have not already, claim your Google Places listing today.
2. Create, verify and optimize your Google+ Business Page.
3. If you already have a Google Places listing, you also have a Google+ Local page. Make sure you have added as much information as possible. This should include name, address, phone number, hours of operation, links to other places on the Web where you can be found, as well as photos and videos.

Using Google+ is a great strategy for helping your agency to master its Internet presence.

How is your agency using Google+ to master your Internet presence? Leave a comment and let me know.

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