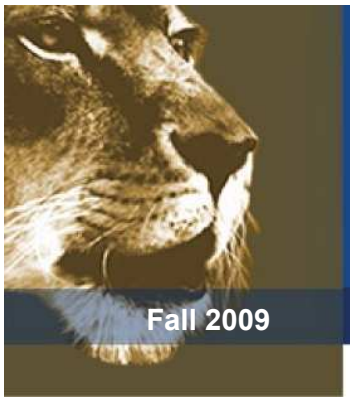

BFL
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The Cover Note

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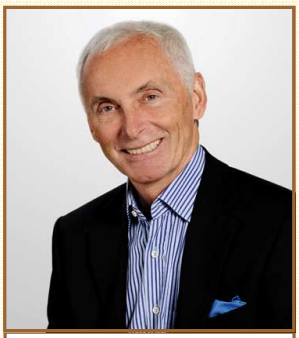


Barry F. Lorenzetti

Every organization understands the importance of purchasing insurance policies which are broad enough in coverage and limits to protect its assets in case of loss, while addressing the idiosyncrasies of its industry segment as well as its own specific operational and administrative needs. After all, claims payment and service are the essence of an insurance purchase.

There has been a lot of chatter from the insurance industry recently on underinsurance with respect to property–a phenomenon which is apparently rampant–but let's not forget all other lines of insurance as well, and the fact that the actual contract wording will determine exactly under what circumstances a claim will be paid in part or in full.

Unfortunately, it is not uncommon for entities to purchase a product whose wording or limits are not adapted to their actual needs in order to save on premiums. Equally common is the company delegating the responsibility of the purchase to an individual within the organization who does not have access to the information required to make informed decisions/ask informed questions at the time of purchase. Of course, it is the Insured's prerogative to choose to assume risk instead of insuring it. In such a case, the Insured must be confident of having all the relevant information at hand before making a decision.

Organizations that are uninsured or underinsured (willingly or not) more often than not make the unpleasant discovery that the loss they incurred is not covered by their wording or that they have purchased insufficient limits.

In a time of economic turmoil, this issue takes on even greater importance as companies sometimes experience a surge of losses/claims while they struggle to stay the course. Some of these losses/claims are unfortunately the result of their own management decisions to try to cut costs. A claim denied because of a wording issue or underinsurance can be potentially more devastating to a company in the current economic climate than in a more stable economy.

In addition to the threat it represents for Insured entities and its expected effect on Insurers' capital, such a surge of claims could no doubt exacerbate the pressures towards hardening of the market as well.

In this issue, Anne Taylor discusses the claims surge and some of the sources of those claims in our feature article *Insurance Claims, the Economic Downturn and Risk Management*. Sébastien Bouchard addresses some of the basic concepts of the "claims made" policies and Tom Guay of BFL CANADA Consulting Services Inc. explores cost containment of group insurance through an Employee Assistance Program (EAP). ♦

Insurance Claims, the Economic Downturn and Risk Management

Anne Taylor , Vice-President and Client Executive
BFL CANADA Insurance Services Inc., Vancouver

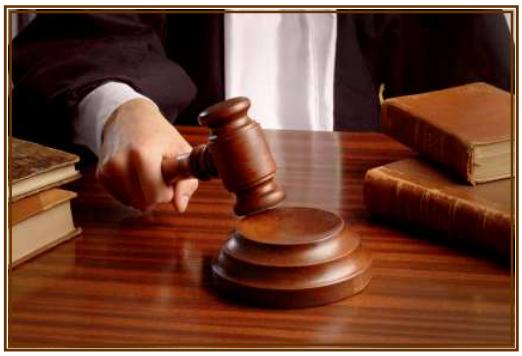
2009 should see a significant reduction of certain types of activities: reduced merger and acquisition activity, real-estate purchases and similar or related transactions.

The outlook for the insurance industry is just the opposite. In an economic downturn there is traditionally an increase in insurance claims.

In the current environment, insurers are seeing more claims arise from business failures, where for example, partners turn on each other, suppliers go unpaid and as a result customers and employees suffer. Even a small business failure can generate claims arising from breach of contract, wrongful termination, discrimination, libel and slander – disputes that in the past may not have ended up in litigation but were resolved with a handshake.

More losses, claims and suits

Today some people look to insurance to make good their financial losses, regardless of what is actually covered by their policies. Policyholders need to be aware that in a downturn, they, as well as their insurers, are exposed to a greater risk of losses, claims and lawsuits. Consequently policyholders should be concerned with preventing losses that could potentially ruin them and their business, by making sure they have broad coverage and sufficient insurance limits. The spectre of an unpaid claim should motivate business owners or managers to perform a thorough review of their insurance contract wordings to ensure their policies address their needs. Insureds should also verify that the limits purchased are adequate; so that any underinsurance is not paid out of their own pocket should a catastrophe occur.



One of the most obvious sources of claims surfacing during a recession are those brought by shareholders and third parties against Directors and Officers. However, less visible sources of claims should not be ignored. Employee morale can suffer when companies downsize, and some employees may even “pre-emptively” suffer a workplace injury, or an illness which requires sick leave, all at considerable additional cost to the organisation, and possibly to insurers.

It is ironic that during difficult economic periods, the very cost cutting decisions that businesses take to improve their bottom line can actually accentuate their difficulties or place them in jeopardy. For example businesses may cuts costs in the following areas:

- Production workforce
- Quality Assurance
- Health and safety

Cost cutting in these areas can lead to serious claims against the business; squeezing fewer employees to perform more work can lead to mistakes, and more workplace injuries. Mistakes in production can mean re-doing or recalling defective products (at additional expense, higher risk of claims/suits, and defeating the purpose of the cost cutting measures). Furthermore, the business may lose qualified workers because of injuries or stress related illness. Less emphasis on Quality Assurance not only increases the possibility of suits from third parties, but also against the Directors or Offices, who may be presumed to have knowledge of the cost cutting measures being implemented. Would-be plaintiffs may jump at such an opportunity! The same applies to a lack of attention to Health and Safety standards, where sloppy practices can lead to ‘on the job' injuries for employees, penal liability for administrators and fines for the company.

There is no magic bullet to relieve a business from financial stress. Directors and Officers should ensure that the risks associated with any cost cutting measures are properly weighed against the potential harm, before decisions are made. Consideration should be given to the scope of insurance available to the organization as well as the limits carried.

Another consequence of the sluggish economy is that insurance claims tend to increase in frequency and severity, and more claims can be exaggerated or fraudulent than under normal circumstances. Clients or third parties may try, unjustly or fraudulently, to obtain resources from a business to compensate them for their economic woes. In some cases, people or companies can also feel that they have been paying insurance premiums for years and ‘need to get some of their money back’. Some of the methods employed are as follows:

- Exaggerated claims
- Staged accidents of thefts
- Protracted litigation
- Nuisance claims

Risk Management Tools

The current economic situation is fertile ground for problematic situations with respect to Risk Management and Insurance. Fortunately there are two basic tools readily available to all organizations: Risk assessment and the purchase of insurance. These risk management tools take on greater importance during a recession. Making risk assessment an integral part of the decision making process is becoming a must, as the very

existence of organizations is on the line these days. It is also important that the business assign the entity's insurance portfolio to an individual cognizant of the inner workings and needs of the business, to secure broad, personalized and effective coverage for the organization.

Finally, these difficult times will require thoughtful decisions and productive measures. Insureds and Insurers face huge challenges as businesses continue to respond to economic pressure; striving to streamline operations and achieve greater cost efficiency. To assess, prevent, assume and insure risks, as well as settle losses and litigation, is a tough prospect under normal circumstances, but can turn into a daunting experience during economic turmoil. ♦

CLAIMS MADE INSURANCE 101

Sébastien Bouchard, Client Executive
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In the current economic environment, it would be unfortunate if an insurer refused to pay a claim on a mere technicality. Claims made insurance is one of the most misunderstood concepts in insurance, and as a consequence, is the source of many claims problems.

There are essentially two types of insurance policies: occurrence based and claims made. The first is the most common, for example, car and home insurance are occurrence based. The latter is generally used for specific types of policies, such as liability insurance and D&O.

What does claims made insurance mean? That the insurer will pay claims made against the Insured while the policy is in force, and note any fact which comes to the attention of the Insured during the policy period and which may trigger a future claim. In other words, for claims made insurance, it is not the date at which the loss occurred, but the date at which the loss is discovered by the Insured that matters. The opposite is true for occurrence based insurance, where it is the date at which the loss or damage occurred (i.e. water damage) that determines which insurance contract will apply.

Claims made insurance is appropriate, for instance, for professionals whose work extends over a period of time (successive mandates), as it is sometimes impossible to pinpoint the date at which the damage/loss occurred. For example, a securities consulting or engineering firm makes a mistake in its recommendations or plan design in 2007, and it is only discovered in 2009, two years after the contract/ work has been completed. In claims made insurance, it is the first of two possible dates that will require the insured to inform the insurer of a potential claim and will tie the insurer to the loss: either (1) the date at which the error, omission or negligent act was discovered by the firm (in 2009), OR (2) the date at which the victim makes a claim against the firm (no claim made yet). The date at which the error was made (2007) has no direct impact.

In claims made insurance, the insured must maintain continuous coverage both while carrying out their professional activities and afterwards. This way, they are sure to be covered, whether an error, omission or negligent act which could give rise to a claim is discovered, or a claim or suit is made against them alleging an error, omission or negligent act.

Problematic situations usually occur when a change of insurer has been handled incorrectly, when activities have ceased, or when the policy requires the insured to report any event or claim during the same policy period as its discovery.

Therefore, prior to a change of insurer, it is important to inform the insurer of any claim or circumstance which may give rise to a future claim, and which you were made aware of during the policy period. For large companies, we recommend informing all employees of an imminent policy renewal, and asking them to communicate any known claims in order to provide the insurer with accurate data. In addition, some insurers will allow a change of the definition of 'insured' with regard to loss or claims reporting, limiting it to certain positions within the company. If the individuals who hold those positions are not informed of claims or of events leading to potential claims or lawsuits, the possibility of problems is reduced.

It may seem surprising that a company fails to report a claim to the insurer. Yet, this situation is often the result of ignorance or misunderstanding of the policy's terms and conditions by the people that are the most likely to be informed of any problems or potential claims: the company's production employees and the legal affairs department. It is also possible that the person in charge of the company's insurance portfolio does not fully understand the definition of what can give rise to a claim under the policy. For example, a simple e-mail sent by a third party blaming the insured for an error or omission, may actually be considered a claim under the policy, and should therefore be communicated to the insurer. It is highly advisable to inform the insurer of any potentially problematic situation and let the insurer decide what is or is not a legitimate claim. This is common practice and your premiums will not be affected by the number of reports you submit if no claims develop.

In conclusion, with respect to all claims made policies, we recommend that you:

- fully understand the trigger mechanism
- implement effective communication channels with personnel, allowing quick reporting of facts and information that may trigger a policy
- report any unusual situation to your insurer, as a precaution. ♦

CONTROLLING THE COST OF GROUP INSURANCE THROUGH EAPs

Thomas Guay, President
BFL CANADA Consulting Services Inc., Montreal

In today's economy, employers are concerned more than ever over the rising costs of their group insurance plans. A major component of cost escalation is the increase in disability claims, absenteeism and lost productivity. To help contain these costs, companies are turning to Employee Assistance Programs (EAPs). EAPs are quite often part of a group insurance contract and sold with a fixed premium per employee.

An EAP is an employee benefit that covers all or part of the cost of employees receiving counselling and advice in dealing with stressful issues in their lives. These services are provided by a third-party rather than the company sponsoring the plan. The company receives only summary statistical data from the service provider. Employees and their

dependents names and services received are kept confidential.

EAPs can be an important first step for many employees seeking advice and support. It gives them the opportunity to discuss and explore their problems in complete confidence with an experienced professional. It will help the employee in developing a practical plan of action for resolving their problem.

Studies have shown that EAPs can reduce levels of stress in the workplace by more than 50%. Levels of sick leaves and absenteeism fall by 25 to 50% and levels of substance abuse are also reduced.

The majority of employees who use the services of an EAP provider are highly satisfied with the results. They would use the service again and recommend it to their colleagues.

Not all plans are the same. Some plans offer more comprehensive services than others. Most plans will limit the number of visits to twelve per annum with a professional provider such as a psychologist or family counsellor.

The level of service provided will, of course, dictate the price of the product. Several insurers offer the service as part of their long-term disability (LTD) benefit and the cost is included in the LTD premium. As a result, this cost is often overlooked by the plan sponsor. An insurer will offer the service as part of their LTD for early intervention in managing their disability claims. The insurers that provide the service feel that early intervention by means of an EAP will significantly reduce the probability of an LTD claim, as well as reduce the duration of a claim.

A stand alone contract with an EAP provider, for groups with fewer than 250 employees, runs around $6 per month per employee for single coverage and $12 per employee for family coverage. Larger employers tend to negotiate directly with a provider for a stand-alone contract and pay as the services are provided. The major life insurance companies negotiate with a provider to get discounted rates as compared to an employer negotiating directly with the EAP provider.

The services that are most often provided, either by phone or face-to-face, are outlined below:

- **Personal:** fatigue, sleep disturbances, general anxiety, loss of motivation, loss of self-esteem, weight, stress, depression, isolation and bereavement;
- **Dependency:** alcohol, drug and medication abuse as well as compulsive gambling;
- **Financial:** support with credit and debt management, bankruptcy and budget planning;
- **Legal:** family law, divorce, child support and custody;
- **Eldercare:** support and assistance for elderly parents in researching retirement homes, home care and psychological support;
- **Family:** relationship issues, separation or divorce, marital conflicts, communication and parenting problems;
- **Childcare:** support and assistance researching daycare services and home care nursing;
- **Work:** stress, burnout, interpersonal problems with supervisors and/or co-workers, difficulties adjusting to change in duties and loss of interest and motivation at work.

With such a wide range of services and the resulting positive impact on employee well-being, overall, effective EAPs can prove to be a very wise investment for employers. ♦

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