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Editor's Note

by Jane M. Damon, CPCU, CPIW, CIC

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Damon is past president of the CPCU Society's Dallas Chapter, was national new designee representative, and currently serves on the national Risk Management Section Committee as co-editor of the *RMQ*.

The *RMQ* editors and authors have been working overtime to catch up with our publications this year. Unfortunately, we got a little behind at the beginning of the year, but we wanted to get back on track and provide you with the informative publication that you have grown to expect. We have compiled another great set of articles for you.

Our regular authors **Jerome Trupin, CPCU, CLU, ChFC,** and **George L. Head, Ph.D., CPCU, CSP, CLU, ARM, ALCM,** have again provided excellent articles and information. Michael Moody, ARM, will return with his regular feature article in our next publication.

Earl D. Kersting, CPCU, ARM, ALCM, AU, AIC, AIS, AAI, past president of the CPCU Society's Memphis Chapter and past member of the Risk Management Section Committee, has provided an article on the changing business climate. **Jeffrey Moerschel, CPCU, SCLA,** discusses how to maximize your claims handler's performance through audits; and **Hal MacLaughlin, J.D.,** shows us how to manage litigation risk. **Patrick Mertes, CPCU, APA, CIPA, AU,** provides insight to the audit process and how to prepare for an audit.

Please feel free to let us know your thoughts on the articles, what you would like to see, what you like and don't like. If you would be interested in providing an article, please contact me at jane.damon@wachovia.com. We welcome all authors and commentaries. ■

What's In This Issue

Greetings from Your Chairman

by Patricia A. Hannemann, CPCU

Patricia A. Hannemann, CPCU, is chairman of the CPCU Society's Risk Management Section. Her insurance career consists of more than 20 years' experience working in agencies and companies. Currently, she is working with The Insurance Society of Baltimore in promoting and teaching various insurance classes. Hannemann served as the CPCU Society's Maryland Chapter president, and chaired both the Public Relations and Good Works Committees. The Maryland Chapter's CPCU Excellence Award was presented to her for spearheading the Good Works Committee and establishing the chapter's scholarship fund in connection with the SADD organization. Serving on the CPCU Society's Chapter Awards Task Force, she helped create and judge the current Circle of Excellence Recognition Program. Hannemann received her CPCU designation in 1987, and holds bachelor's and master's degrees in music from the Manhattan School of Music, and a master's degree in business from Johns Hopkins University.

We are approaching those colorful days of fall when we can sit back and reminisce about what happened over those hot summer months. As with all months, and the year in general, time seems to race by faster and faster. Could it perhaps be the pace of life we all lead or are some of us just moving a little slower?

As I write this note, it is one of the hottest days this summer. But, the fall is coming and so is the CPCU Society's Annual Meeting and Seminars that is being held in Nashville this year in September, almost a month earlier than usual. So hopefully you thought ahead and registered for all of the exciting seminars and events. Most of you will receive this newsletter after visiting Nashville; I sure hope you were able to see some of your Risk Management Committee Members at the Section Booth.

This year your Risk Management Section had two presentations. One was a collaboration with the Information Technology Section on Monday, September 11, entitled "Predicting and Preparing for Disasters—A Case Study Approach." The second one was on Tuesday, September 12, and entitled "Employee Dishonesty and Employee Theft: Coverage Choices for an Often-Overlooked Exposure." Many thanks to Jerome Trupin, CPCU, CLU, ChFC, and Richard Berthelson, J.D., CPCU, for their long hours of preparation for these presentations.

In our next *RMQ*, we will have reports from our roving reporters on our Risk Management sessions, our new committee members, and of course lots of excellent articles. Don't forget, if you have an article you would like to submit, please e-mail our editors **Jane M. Damon, CPCU, CPIW, CIC,** at jane.damon@wachovia.com, or **James Baggett, CPCU, CIC,** at jbaggett5@cox.net, or me at pah@hoco150.com. We are always pleased to print articles written by members of our section or one you believe would benefit everyone interested in learning more about risk management. If you have a desire to be on the Risk Management Committee and build the future of the section, please let **John Kelly, CPCU,** jkelly@cpcusociety.org or me know. ■

Not If, But *When* Will It Happen? Are *You* Prepared to Prepare Your Clients?

by Earl D. Kersting, CPCU, ARM, ALCM, AU, AIC, AIS, AAI

■ **Earl D. Kersting, CPCU, ARM, ALCM, AU, AIC, AIS, AAI,** is assistant risk manager of The Kroger Co., Delta Division, in Memphis, Tennessee. He is a past president of the CPCU Society's Memphis Chapter, and a past member of the Risk Management Section.

- Five years ago, an act of international terrorism in the United States was a perceived threat *in theory*, but few thought it could actually occur here, until after it did.
- Two years ago, few of us imagined that a major United States city, as large as New Orleans, could have been nearly erased from the map due to a natural disaster, but it almost was.
- Last year, few of us had ever heard of avian influenza, yet today it is a part of everyone's vocabulary, although few really know what to expect from this threat.

In the United States, we have a general tendency to look at certain events as things that happen somewhere else—perhaps in a lesser-developed third-world

country—but don't and won't happen to us. Then we're caught off guard when it happens in our own backyard. As the above events exemplify, it can and it does happen here.

Our business climate is changing at an incredible rate, and as risk management and insurance professionals, we must remain ahead of the changes if we are going to remain a viable industry, and remain not only solvent, but also profitable in the long run. A question that presents itself is how do we know what to anticipate when events such as those aforementioned were unimaginable just a few short years ago?

The reasonable solution is to maintain current in our education, to remain abreast of world events, and to then apply that education and knowledge to our own environment. The nature of our industry demands that we don't allow our personal professional knowledge base to become obsolete. We must look toward the events occurring not only in our own backyard, but we must use events occurring throughout the world at large as provocation to consider how such events, should they occur locally, would impact our business and our clients, and how we can best protect their and our interests *now*, in advance of such event.

A case in point: We are all aware of the New Madrid and the San Andreas faults, yet how many of us have worked with our clients and our colleagues in those areas to educate and prepare them for a major earthquake? It could begin with actions as simple as helping them maintain updated current emergency contact information and alternative methods of contact should the telephone systems be rendered inoperable, and providing them with checklists of emergency supplies that would be essential yet unavailable immediately following an event so that such materials could be kept on hand in advance of their need; or it could be a more formalized process whereby we conduct on-site consultations with those clients and offices, making site-specific recommendations and offering guidance regarding how to create and implement site-specific emergency response plans.

No matter what approach we take, we must realize and accept two important premises.

First: It ***could*** happen here. Earthquakes are not limited to Indonesia (February 19, February 26, and March 28, 2005), Iran (February 22, 2005), Pakistan (October 8, 2005), and the third world.

Second: The manager of an insured manufacturing facility in southern Missouri, along the New Madrid fault, and the owner of an insured production studio in Los Angeles, along the San Andreas fault, are concentrating their efforts and resources on production and output, and not on their response following an earthquake; yet as risk management and insurance professionals **we must accept as *our* responsibility the job to plan for such events** and to help prepare those sites and facilities we insure or operate so that in the event of a catastrophe, the loss of life and property is minimized as much as humanly possible.

At other times, we must rely upon our education and experience to help our clients and our business units prepare for the unknown, so that should it unfold, the response is well thought out and not impulsive or haphazard. No one knows the impact, if any, that the avian flu may have upon our clients and colleagues. However, you and I, as risk management and insurance professionals, know that a well-developed plan of action will minimize and mitigate losses should a pandemic arise.

It is therefore *our* responsibility to help others prepare for what they may believe is yet another *theoretical* threat that can't happen here, in this developed United States. We must use our skills to investigate the potential impact of such a pandemic and to contemplate the best methods for dealing with such an event. We must then share our findings with our clients and counterparts so that losses and interruptions are minimized should the unthinkable occur.

For example:

- What if employees fear leaving their homes, or are unable to leave their homes? What will our fuel-producing clients do to continue output and keep food and supplies moving to where they are needed?
- What will our telecommunication clients do to keep lines of communication open during this critical period of need?
- What will our retail food clients do to maintain product availability, or our pharmaceutical clients do to maintain production and distribution of life-necessary medications?

Only through advance preparation can plans be created to address such questions, and only through our continued education and our awareness of events unfolding worldwide can we help our clients and counterparts consider, and effectively prepare for such events.

Major earthquakes, city-leveling floods, international terrorist attacks, a biological pandemic—these are not limited to the far side of the globe. How will you help your clients and counterparts prepare for what they may believe won't or can't happen to them? How prepared are you to help them prepare? ■

Tell Insureds to Save Old Policies and to Complete Applications Accurately

by Jerome Trupin, CPCU, CLU, ChFC

■ **Jerome Trupin, CPCU, CLU, ChFC,** is a partner with Trupin Insurance Services. He holds a B.S. from the School of Management at Syracuse University and an M.S. from the Graduate School of Business at Columbia University. Trupin has acted as an adjunct instructor at Westchester Community College, St. John's University, Tobin Business School (formerly The College of Insurance), Marymount College, and Iona College. He's the educational coordinator for the CPCU Society's Westchester Chapter, past president of the Westchester Chapter, and past president of the North Jersey Chapter. Trupin is a licensed insurance agent/broker in New York, a licensed insurance producer in New Jersey, and a licensed insurance consultant in New York, and has been a principal and contributing author on numerous publications.

What connects these topics are two recent court decisions.

In the first case an insurer denied coverage contending that the insured couldn't prove that it had had a policy. Contrary to what insureds often expect, insurers do not save copies of old policies; it's the insured's obligation to prove that coverage existed.

In the second case, when the claim was reported, the insurer sought to void the policy from inception because of an alleged misrepresentation in the application.

The first case involved coverage for asbestos exposure claims dating from the 1960s. The insured was unable to locate a copy of the policy but did find a certificate of insurance showing coverage for the 1965 year. The insured also presented other evidence, including testimony from the agent who wrote the policy that he had obtained coverage for the insured from the insurance company, a statement from a former employee of the insurance company that he recalled issuing the policy, and documents from 1967 and 1968 dealing with the transfer of coverage from the insurance company to another insurer. In spite of this evidence, the insurance company contested coverage and when the first court decided against it, it filed an appeal, which was also unsuccessful. *ACMAT Corporation v Greater New York Mutual Insurance Company*—No. 25099—Appellate Court of Connecticut—April 12, 2005-869 Atlantic Reporter 2d 1254

The second case involved a $4.7 million employee dishonesty claim—not relevant to this discussion, but the insured had only $1 million in coverage. How many of your clients have inadequate employee dishonesty coverage? In reviewing the accountant's report of its investigation of the defalcation, the claims examiner noted that it showed that the embezzler reconciled a checking account over which he had signatory authority. The policy application asked whether employees who reconciled monthly bank statements "also either sign checks, handle deposits or have access to check signing machines or signature plates." The insured had answered the question "No." The claims examiner consulted with a fellow examiner who agreed with her that this constituted a material misrepresentation. After discussion with in-house counsel, the matter was referred to outside counsel and the insurer brought a declaratory judgment action seeking recision of the policy based on intentional misrepresentation. Again, the insurance company was unsuccessful and is in fact facing penalties including paying the insured's costs and attorney fees and a doubling of the award. The insurer is appealing the decision. *Federal Insurance Company v HPSC, Inc.*, 2005 U.S. Dist. Lexis 19713; 2005 WL 2206071 (U.S.D.C. Ma. 2005)

In both cases the insured prevailed, but think about the time, money, and aggravation involved. It's not the way to get coverage and, as with any court case, it could have gone the other way. The courts didn't say that the insurers' legal theories were in error, only that in these cases the facts didn't support their decisions. ■

Preparing for a Premium Audit

by Patrick Mertes, CPCU, APA, CIPA, AU

- **Patrick Mertes, CPCU, APA, CIPA, AU,** started his insurance career in 1972 and worked with various commercial insurance carriers, serving in various positions during 1972 to 1986. In 1986, Mertes joined The Hartford insurance company as a field auditor and is now the premium audit manager for the states of Maryland, North Carolina, South Carolina, Virginia, and the District of Columbia.

  Mertes has earned professional designations as Chartered Property Casualty Underwriter, Certified Insurance Premium Auditor, and Associate in Underwriting. He also serves on the Industry Practices Panel Committee for the Premium Audit Advisory Service.

Throughout the many years of dealing directly with insurance clients, agency personnel, and underwriters, the question has arisen as to how to prepare for a premium audit. The premium audit process should not be a mystery, and so to attempt to demystify some of the actual operation of this premium audit process. The following is offered to assist in preparing for a premium audit.

Premium Audit—Terms of Insurance Contract

The annual premium audit represents an attempt by the insurance carrier to determine actual exposures and the premium for any auditable portion of a policy. Insurance company auditors are permitted by the policy provisions to make a complete audit of records to establish the correct/actual exposure and premium for the policy term. This includes an examination of the cash journal, general ledger, payroll records, income tax records, social security reports, unemployment insurance reports, checkbooks and contracts, and any other records that may be pertinent to establishing the exposure of the risk. Under the terms of the insurance policy, the carrier has the right to examine records up to three years after the policy expires and make any changes or modifications as allowed under guidelines as set up by each individual state. This auditable portion of the policy is based on estimates made at policy inception and at the end of the policy period; an audit is performed to provide the actual exposures, along with a billing for the actual premium. Once the audit is completed, there can be striking differences between what has been estimated on the original policy and as to what the actual exposures are. Sometimes this striking difference is misconstrued by the auditor because of lack of proper information or misunderstandings; sometimes it is because of a change of operations. However, the key element is for the policyholder (contact person) and the premium auditor to have open dialogue regarding the operations of the policyholder.

The first issue that needs to be discussed is what basic assumptions the auditor has when he or she reviews the policy that will be audited. One of the first is that the policyholder who purchased the insurance is made aware by the individual selling the policy, that there will be an audit per the contract written. The second assumption is that the policyholder understands what information is needed, which is commonly remuneration or payroll (including payments to subcontractors) and gross sales, although there may be other auditable exposures as designated in the contract. Even though the auditor can provide this type of information, the insured should have a basic understanding of the audit process, the records needed, how they will be reviewed, and how the rules are applied. The audit is usually completed after the expiration of the policy, or sometimes monthly, quarterly, or semi-annually, in certain policies. The advance information as provided to the policyholder creates a foundation from which the auditor can provide his or her expertise and assistance in completing the premium audit accurately.

Always keep in mind that for those states governed by NCCI, classifications used are those that have been assigned by NCCI. The goal of the classification procedure for NCCI is to assign the one classification that best describes the type of business operating in a state. Separated from that one basic classification would be the standard exceptions for that state that would not apply to the one basic classification. What needs to be kept in mind is that it is the business that is classified, not the individual employments, occupations, or operations within the business. If there is a separate operation that is outside the scope of the basic operation of the business and meets the criteria as established by Rule 1-D-3, then a separate basic classification can be added to the policy. Keep in mind that it must meet all of the criteria to raise the separate basic classification. It is always best to refer to the basic manual from NCCI to make sure that proper classification procedures have been followed. Various states have different guidelines for how classifications are assigned; therefore, make sure that you check with the particular state rules for guidance.

Types of Audits

There are three basic types of audits: the physical audit, the telephone audit, and the voluntary statement audit. We are only reviewing the physical audit process although most of the information provided could be used with the telephone audit as well.

Continued on page 6

Preparing for a Premium Audit

Continued from page 5

Premium Audit Process

The process for the premium audit starts out with the initial contact from the auditor. This may be by phone or by letter (e-mail) and this contact will list the policies to be audited, along with the necessary records that will be reviewed. It is very important that the policyholder understands which records are to be reviewed; the auditor should be contacted if any questions arise as to reason for the use of these records. Such records as federal and state tax returns, books of original entry, general ledgers, cash disbursements journals, job contracts, certificates of insurance for subcontractors, profit and loss statements are all essential components for the auditor to obtain accurate information and to correctly determine the exposures under the insurance contract. It is also important that if an appointment cannot be kept, that the auditor be notified immediately. Most auditors run on very tight schedules and will allow a certain amount of time for each audit appointment. Therefore, an auditor should immediately be notified if an appointment cannot be kept.

The auditor should be advised as to who the primary contact person is within the company. For the direct benefit of the insured, this contact should have a thorough knowledge of the operations of the company, the duties of all the employees, and how the company operates along with an understanding of all the records requested. In the absence of this type of information supplied, the auditor will have a difficult time providing an accurate picture of the exposure. Again, this is to the direct benefit of the insured. Many of the completed audits come back for a reaudit for the simple reason that the policyholder did not provide a contact that was knowledgeable enough to provide the auditor adequate information and answers to the necessary questions that were asked. Because of that, the premium auditor might have to make assumptions that may or may not be accurate in reflecting the exposure.

When the auditor arrives at the insured's location, it is best to provide a work area that will be conducive to the review of the confidential records. It is less complicated for the auditor and the contact person if there is a quiet and private place to review these records, and where questions can be asked, without fear of uninvited listeners or roving eyes. The ideal place for the audit is always at the policyholder's location where the auditor can see first hand the operations of the business. If done off-site, a contact at the policyholder's company should still be available to answer questions as they arise.

There are many inclusions and exclusions for both payroll and sales, and it is not feasible to list those in this article. These items are found in the basic manuals, which, although not available to most policyholders, can be provided by their insurance representatives (or the premium auditor). However, since the auditor is reviewing records approximately 12 months after the inception of the policy, the proper information should be made available before the final audit is being requested. Records that are accurately and properly maintained assist the auditor in completing the audit quickly and may result in premium savings based on the application of certain premium saving rules. Provided below are some of the key elements that will provide assistance to both the policyholder and the auditor in completing the audit. Having the information below may provide credits for the policyholders, as well as a basic understanding of the rules that the premium auditor uses to guide his or her activities.

Preparation for the Audit

In preparation for the audit, the records should be reviewed to make sure that the auditor can easily break out overtime totals (in most but not all states) in summary and by classification as this is a deduction that the insured is allowed. Premium auditors are not required to perform this breakout of overtime. However, if broken out in summary, by classification and is verifiable by the auditor, a credit can be given, credit being a deduction for the premium portion of the overtime. Check your local state rules for overtime as some states do not allow credit for overtime.

Some manual rules allow the division of an employee's payroll into more than one classification. This is most readily seen for the construction trades. If manual rules permit the division of payroll, records must be maintained that disclose the actual payroll by classification. The split cannot be by ratio or by percentage, but by actual payroll that is assigned to each classification for that individual employee. Certain classes such as clerical, sales, and executive supervisors are not allowed this division. In the absence of the proper breakdown, the entire payroll must go into the highest rated classification for any part of that work.

Executives, Partners, and Sole Proprietors

Executive officers should be identified as those individuals are subject to different classification rules and payroll limits. Partners and sole proprietors, if covered under the policy, are also subject to different rules for both classifications and payroll limits and should be identified. LLC members and managers should be identified as each state has various rules as to how these members and managers are treated for both general liability and workers compensation.

Executive officers of a corporation or unincorporated association are the president, vice president, secretary, treasurer, or any other officer appointed in accordance with the charter or bylaws of such entity. These rules may vary by state, so it is best to be aware of each state's specific requirement. Classification for officers is also treated differently. Executive officers must be assigned to the classification that applies to the principal operations in which the executive officer is engaged. There are exceptions, and the workers compensation manual should be checked for these exceptions.

Be aware that there are certain inclusion and exclusion rules for officers that vary by state. Each state should be checked for those various rules.

Workers Compensation

When a policyholder hires subcontractors or independent contractors, certain rules apply. For workers compensation most states hold the policyholder responsible for injuries to the employees of their subcontractors. In the absence of other insurance, most state laws hold a contractor responsible for injuries to employees of any subcontractors if the subcontractor doesn't carry workers compensation insurance. Certificates of insurance must be available at the time of audit for those subcontractors with employees in order to avoid additional premium charge. Subcontractors who have no employees and whose duties closely resemble those of an employee may be considered employees with the corresponding appropriate premium charges. In most cases, proof of current workers compensation coverage for that subcontractor will allow the auditor to exclude that portion of the amount paid to those subcontractors. If there is no coverage available, the appropriate charge will be made for that uninsured subcontractor.

General Liability

For general liability, a policyholder may be held responsible for injuries or damage caused by third parties (subcontractors) if there is no other coverage available or if the limits under the general liability are considered inadequate. There are various rules for each company to determine what is considered adequate. For both workers compensation and general liability policies, it is important to provide insurance certificates (workers compensation and general liability) for those subcontractors you use, and those certificates should cover the policy period of the policyholder's policy.

On the general liability policies, the most common basis of exposure is sales and/or payroll. Also included for some policies, is the cost of adequately insured subcontractors.

Receipts—The gross amount of money charged by the insured for operations by the insured or by others during the policy or audit period, including taxes other than those collected as a separate item and remitted directly to a governmental division. Records should reflect any foreign or inter-company receipts/sales.

Sales—The gross amount of money charged by the insured for goods and products sold or distributed during the policy, or audit period, and charges during that period for installation, servicing, or repair, including taxes other than those collected as a separate item and remitted directly to a governmental division. Records should reflect any foreign or inter-company receipts/sales. For some classifications, installation is separately rated.

Remuneration (Payroll)—The entire remuneration earned during the policy or audit period by all employees other than chauffeurs or aircraft pilots, subject to applicable overtime, and payroll limitation rules. In most cases, clerical, salesmen are also excluded from computation.

Independent Contractors—This coverage is considered secondary liability coverage for injury or damage caused by independent subcontractors. The premium is based on the total cost for all work let or sublet in construction to the subcontractor.

Automobile

On premium audits for automobile policies, the following records are needed:

- Automatic coverage frequently applies to new and replacement vehicles. In addition to accurate descriptions of the units, the auditor needs the date of purchase or sale, the purchase price, garaging location, gross vehicle weight, and the vehicle identification number.

Premium Audit Closure

Once the audit is completed, the records reviewed and all of the auditor's questions have been answered, there are a couple of key acts for the policyholder. First, any questions or doubts regarding that audit should be addressed by the auditor. The auditor will welcome your questions. Second, ask for a copy of the audit. Although most auditors do the audit via laptop computers, the policyholder should ask for a copy of the audit to be sent "personal and confidential" to the contact person. This provides the policyholder with the backup information for the charges that will be shown on the premium adjustment statement that is based on the audit as performed by the auditor. Third, once the premium adjustment statement is received, the policyholders should compare this to what was shown on the audit and what was written on the original policy. Finally, if there is any questions about either the audit or the premium adjustment statement, contact should be made with the premium auditor or the sales representative (agent).

In my years of auditing and dealing with the above issues, there is one key aspect that will drive a successful premium audit. The premium auditor should have a contact individual at the policyholder's location that is knowledgeable about the company operations, can speak in detail about the various duties of the individuals and the operations of the company, and be willing to take the necessary time to provide that information. The policyholder's understanding of the audit process and what the premium auditor needs to complete the premium audit will provide, in most cases, the successful outcome of the premium audit. ■

Managing Litigation Risk

by Hal MacLaughlin, J.D.

- **Hal MacLaughlin, J.D.,** is of counsel to the Maryland law firm of Lord & Whip, P.A. and heads the litigation risk practice. He has more than 29 years of experience and is a past president of Maryland Defense Counsel, Inc., a statewide organization of more than 600 defense attorneys dedicated to the integrity of the civil justice system. MacLaughlin is a past co-chair of its Judicial Selections Committee and currently serves as MDC's liason to the Executive Branch of Maryland's state government.

  MacLaughlin graduated from Gettysburg College in 1971 and earned his law degree from University of Baltimore in 1975. He is a member of the DRI and the Maryland State Bar Association (Insurance Negligence and Workers Compensation Section).

Insurance companies, brokers, and businesses of all types routinely have a loss prevention program. Loss prevention may be broadly defined as those steps taken to reduce accidents in the workplace. Unfortunately, the typical loss prevention program is only one-half of the risk equation in today's litigious environment; it is an effort to avoid litigation.

For example, a loss prevention program developed for malls, individual stores in a mall, or supermarket chains can include the placement of non-slip mats on the floor or under a rug, the regular cleaning and monitoring of heavily trafficked areas open to the public, the appropriate placement of warning devices, the preparation of accident reports, and the prompt identification and correction of unreasonably dangerous conditions. Loss prevention departments within carriers and brokers routinely advise their clients accordingly. This approach, while necessary and useful, is only one-half of the more complex, problematic risk equation.

The law has only a limited relationship to reality. In the courtroom, reality is created by the rules of evidence, the rules of procedure, and substantive principles. These elements represent the other half of the loss prevention equation—this half is often misunderstood, overlooked, or simply ignored. As a trial lawyer for the past 28 years, I have seen the financial benefits for clients when a solid loss prevention program is synthesized with the legal realities created by the rules of evidence, the rules of procedure, and changing litigation trends.

What should a business, carrier, or broker do within the parameters of a balanced litigation management program to reduce inflated settlements and the potential for adverse or runaway verdicts? What should a business, broker, or carrier not do?

A business should not aid the plaintiff or claimant in helping to prove his or her case. In the absence of an effective litigation management program, this is often the result. By way of example in the liability defense of malls, shops, and grocery chains, businesses frequently utilize standard forms and expedient procedures for the investigation of onsite accidents. These ubiquitous forms are typically titled, "accident reports." They are routinely (unless privileged—which is often not the case) admitted into evidence in both state and federal courts as a record kept in the ordinary course of business. Although conveniently entitled, "accident report," how does one know that an accident has occurred? Because the potential plaintiff says so? Because an investigating employee notes an "accident report"? The better litigation management approach is to term this type of business form an "incident report." The difference is that an "incident" indicates that something out of the ordinary or unusual has happened. It does not implicitly accept an unusual occurrence as an "accident." This is not merely a semantic difference, it is both legally and substantively important.

A jury is not made up of claims professionals, risk managers, and lawyers. A jury is ideally selected from a cross section of citizens from a particular venue, and unfortunately the selection process often excludes claims professionals, risk managers, and lawyers. If a jury is presented at trial with an "accident report," by definition, an accident has occurred (why would it have been filled out otherwise?). It is not the defense lawyer's job alone to explain this distinction to the jury. The written word is often more powerful than a verbal assertion. We as attorneys, risk managers, and claims professionals speak our own professional language of "contributory negligence," "assumption of the risk," "negligence," "comparative fault," "causation," "mitigation of damage," etc. A jury does not care—it is not their language and it is not the language of common sense or practical, everyday experience. Is there written

documentation of an accident? What does that documentation say? Does that written accident documentation go into the jury room during deliberations? This is the type of evidence that makes an impression on a jury.

In the aforementioned example, the standardized "accident report" typically has a section, which requires a "description of accident." A busy investigating employee or store/mall manager who is caught up in the demands and responsibilities of the typical work day arrives at an incident scene, listens to what the individual says, and too often does an ad-hoc "accident analysis," which is contemporaneously written down on the "accident" form. An example of a typical description would be ". . . the customer slipped and fell on an olive pit next to the Food Bazaar." Is that the plaintiff's verbatim statement or is that an accident analysis done by the shop manager, mall security, or store employee who is not schooled (nor should he or she be) in formal accident reconstruction?

What does our investigating employee actually know? Usually, not much. Absent a witness, how does the investigating employee know that the individual involved in the incident was a "customer?" Was the person entering the store to use the bathroom? Was the person entering the store to take a shortcut to the mall parking lot because he or she was too lazy to use a marked mall exit?

What have we done as a legal/claim/risk management industry by creating universal, common business templates as litigation management tools? In the foregoing example, we have tacitly acknowledged to the jury that there was a customer who had an accident. The accident was probably caused by an olive pit on the floor in an area that we were responsible for cleaning. The small olive pit may constitute a dangerous condition. While these assumptions are refuted and explained by the competent defense lawyer, we begin our explanation of the case to the jury in a defensive position. Plaintiff goes first before the jury and can build a case using our "form," our standards, our procedures as opposed to contemporary, customized litigation management templates.

In the foregoing example, the only legal element of the plaintiff's prima facie case left to prove is whether or not we "knew or should have known" about the potentially dangerous condition prior to the incident.

Good litigation management practices require the crafting of policies in light of courtroom reality, the rules of evidence, and procedure.

By not properly managing litigation risk, by not understanding "legal reality," we have provided the jury written documentation to support the validity of a plaintiff's claim. It represents strong, common-sense evidence against our defendant.

What should we do? When properly managing litigation risk, we must take a distinctly different but complimentary approach to "loss prevention or loss reduction." Any document prepared in the ordinary course of business should be titled an "incident report." We are not going to acknowledge one way or the other whether or not there was an "accident" or whether the plaintiff was a "customer." Mall security, store managers, and store employees are busy. An incident report should contain a verbatim "statement of the individual involved" and the manager should only write down exactly what the individual tells him or her as to what occurred. Why should we do this? Litigation reality. At trial, this is an admission of a party opponent and can be admitted into evidence before the jury. This initial statement reduced to writing in an incident report may contradict what the plaintiff later states in answers to interrogatories or at a deposition. If there is a contradiction between the original statement, the answers to interrogatories or at a deposition, the jury is more likely to believe what is contained in the statement that was made contemporaneously with the happening of the incident. Also, the plaintiff's credibility is more easily and effectively attacked. Memories are more suspect and less reliable when we enter a courtroom one to three years after the occurrence.

Another example is the proper use of video or digital cameras. They can be a helpful litigation tool. Cameras are an important part of loss prevention and managing litigation risk, particularly where shoplifting and slip and falls are prevalent. In light of the potential for a lawsuit, it is essential to save the mall or store video/digital recordings taken on the date of the incident. Can we isolate on the tape or digital recording the sections relevant to the incident? Are they easily accessible and can the original tape or digital program be easily utilized in a courtroom? Can the individuals on the tape be positively identified? Normally, the video/digital cameras are running on the date of an incident. Despite this fact, "recordings" are often frequently erased or taped over at the end of a business week without any thought to the advisability of litigation management.

Good litigation management practices require the crafting of policies in light of courtroom reality, the rules of evidence, and procedure. To do otherwise is to address loss prevention without litigation management. This is the equivalent of a peanut butter and jelly sandwich without the jelly. By merging loss prevention with the management of litigation risk we reduce our potential losses by creating for each specific business a relevant, ever-changing risk template. ■

ITINERARY
MARCH 5, 2007

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7	Koblenz	8:30am	overnight
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Departure date: March 5, 2007

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Isn't There a Better Way?

by George L. Head, Ph.D., CPCU, CSP, CLU, ARM, ALCM

■ **George L. Head, Ph.D., CPCU, CSP, CLU, ARM, ALCM,** is director emeritus at the AICPCU in Malvern, PA.

Sometimes property-liability insurers do things that almost embarrass me. As a veteran insurance educator I've learned, written, and taught about almost all of the valid explanations of why insurers draft contracts and follow the practices they do. But now and then some friend or neighbor tells me his or her own personal insurance "horror story" that usually ends by asking, "Now tell me, George, why in the @!#^!*! won't my insurance company pay for **that**?"

And sometimes—even though I can recite most of the industry-approved explanations—I wish that the specific insurance company involved could have found a better way to deal with my friend's or neighbor's particular situation. More broadly, my ethical sense, and I hope your sense of ethics as well, wishes that something significantly better could have been done for all insureds who find themselves in a similar situation. Moreover, our concern for our industry's public credibility should lead us to avoid or rectify situations where insurers appear not only heartless but foolish by acting contrary to their own and everyone's best interests. I know why insurers do what they do—for years I've tried to teach why. But sometimes I know in my heart that there just has to be a better way that's better for insurers, better for policyholders, and better for everyone.

A Thought-Provoking Case

As an actual recent case in point, an intelligent and conscientious friend who owns her own home noticed that the 80-foot tree hanging over the roof of her house had several dead or dying limbs. Furthermore, its massive trunk had rotted out enough to put a two-by-four completely through the hole at its base. Worried that the tree would fall and severely damage the house, she called a tree expert who then recommended that the dangerous tree be removed. His estimated cost for removal was $6,000.

My friend next called her insurance agent, who said that her homeowners insurance policy does not cover the felling and removal of trees, even clearly dangerous ones. "Wait until the tree falls and damages your house," the agent advised. "Then call us back and we will see what we can do." This type of response—heartless because it lacks true concern for the public, foolish because it ignores what is best for the insurer and the insured—drives me to ask, isn't there a better way to respond to prudent policyholders who want to prevent avoidable loses?

My friend, whose budget could not easily generate an immediate $6,000, also had questions for her insurance agent. Because spending $6,000 now would certainly save both her and the insurer from a much more expensive, perhaps even a total loss to her home, she asked if her insurer could help in some other way. For example, would the insurer lend her the $6,000 on favorable terms or perhaps subsidize some of the cost of cutting down the tree? "No, we don't do that," her insurance agent replied—another heartless and foolish response. Again I ask, isn't there a better way?

Challenging Some Traditions

My Institute colleagues tell me that this kind of response is neither heartless nor foolish; it is just economically necessary because insurers have no other real choice. My colleagues say that insurers can afford loss control measures only for larger, commercial lines policyholders. For typical personal lines, it would not be cost-effective. They tell me further that insurers do not have the money to pay for their representatives to visit every policyholder who calls with a seemingly sensible suggestion. In addition, my colleagues say, insurers need to safeguard themselves and their honest policyholders from those few but devious insureds who would try to get their insurers to pay for routine maintenance under the guise of "loss control." We know, George, that your friend is honorable and conscientious, but there are always others who will try to take undue advantage of their insurance. Since we have to treat every policyholder the same until we have good reason to do otherwise, all any homeowners' insurer can do for an insured like your friend is wait until her tree falls. After it falls, George, we know your friend will call again. Then her insurance can do its proper job.

I must disagree. Telling my friend and other similar policyholders that their insurer will do nothing until after a loss occurs very powerfully conveys at least three highly negative messages. First, it tells policyholders that personal lines insurers do not really care about reducing covered losses. So why should we care, these insureds quite naturally ask—just let the insurance company pay. That's apparently all they want to do.

Second, by refusing to support the loss control initiatives of personal lines policyholders, an insurer clearly signals that it does not really care about these insureds as people. For example, my friend whose large tree is about to fall realizes that it probably will crash into her upstairs bedroom. Because she cannot afford to cut down the tree, she feels her only viable choices are to sleep in her bedroom and risk injury, possibly death, or to sleep downstairs on the couch in order to avoid worry. Neither choice is good. Should insurers force their policyholders to live under adverse

conditions just to avoid paying for a preventable loss—especially when that loss could bring injury or death?

Finally, insurers that consider loss control for personal lines to be essentially a game of just waiting for losses to happen unintentionally send another very negative message to all those policyholders who never have had a loss. The message: The premium you pay is going up mainly to pay for the losses of other insureds in your premium rating class. The insureds who have yet to have a loss are bound to wonder why living claim-free is cost-effective. In my friend's case, especially after so many years of paying high insurance rates, she wonders if it's more economically sensible to let the tree fall on the house in order to get a much-needed remodeling job. She is tempted to that, since the only way for her to get her money's worth out of her insurance is to have a claim, she might as well let the tree fall. If that's the way this game is played, policyholders will soon realize incurring a loss is more beneficial than preventing one. If the insurer doesn't care about loss control for personal lines—and it's the insurer's money—why should the insured care?

A Challenge for You

In short, I think personal lines insurers should care very much about loss control for good economic and ethical reasons. Yet I'm still trapped by the same traditional thinking that holds my Institute and other insurance colleagues captive. From the beginning of our careers, we all have been taught that insurer loss control efforts for personal lines just cannot be made cost-effective—the expenses will always be greater than the savings, surely in the short run and probably long term as well. I want to challenge this thinking, but I am not entirely sure how. Maybe part of the answer is in better initial underwriting of applicants for homeowners and other personal lines insurance. Maybe another part is in better policyholder education to get more insureds to think like my friend who is still waiting for the dying tree to crush her upstairs bedroom. But, if we find or develop more insureds like her, we had better make sure they can readily afford tree service or be prepared to at least help her get the tree removed. I'm not entirely sure just what to do.

So I close with a challenge to *RMQ* readers. Tell me where I'm wrong. Do you think our current personal lines practices with respect to loss control are fine and should not change? Do you think my friend's suggestions for loss control in her case are economically feasible? Do we have an ethical obligation to address these matters, especially when a loss could mean death? Are there other factors that I have not even considered? As my title to this column first asked, do you have a better way? Please write or e-mail me at head@cpcuiia.org. ■

Maximizing Your Claims Handler's Performance through Audits

by Jeffrey Moerschel, CPCU, SCLA

■ **Jeffrey Moerschel, CPCU, SCLA,** provides consulting services through the firm of Jacobson & Ratzel, Brookfield, WI, and can be reached at jmoerschel@jandrlaw.net. The firm's web site is www.jandrconsulting.net.

When it comes to reducing the cost of your workers compensation program, an area that often gets overlooked is the quality of the claim administrator. If your program is loss sensitive, then whether you self-administer the claims, use an insurance company claim staff, or outsource the claims to a third-party administrator, the quality of the claim provider can vary dramatically and result in unforeseen costs. The best way to reduce these costs is to perform a quality audit on an annual basis, initially to set a benchmark of the current performance and then to establish an action plan for improvement.

Additional benefits to conducting an annual audit are: identifying inefficient processes; reducing outstanding reserves by closing files aggressively; satisfying regulators and excess carriers of the quality of your program and use in conjunction with a gain share program. When your claim provider knows you are monitoring his or her performance, he or she will improve results or risk losing your business.

Now that you know there is a benefit to performing an audit, where do you begin the process? There are two reference materials that provide the guidelines for an audit. The first is industry standards known as best practices, which provide standards that are accepted within the insurance industry. The other is the service agreement between your company and the claim handler. Based on these guidelines, the following categories are measured for compliance.

Investigation. This category focuses on the discovery of the facts of the case in order to determine compensability and wage information. Timeliness and completeness of the investigation are measured. Three-point contact with the employer, employee, and physician must be done timely and thoroughly in order to establish the basis of a good claim file.

Recovery. This category determines if there is potential recovery from a third party that is legally responsible for the incident or if there are other sources of recovery such as the Second Injury Fund or other state funds. It is important to complete this investigation early as evidence and witnesses must be identified and preserved. The potential for subrogation is often overlooked as adjusters are focused on the medical aspect of the claim.

Medical and Disability Management. This category determines if nurse case management was needed to reduce the lost time or medical expenses. Such items as return to work, cost containment, and independent medical exams are considered. The service agreement should address which cost containment components are required and when they are utilized. The use of nurse case managers can reduce the medical and disability portion of the claim. However, it is the adjuster's responsibility to manage this activity.

Evaluation. This category determines the action plan for resolution of the case and provides the basis for determining reserve adequacy and disposition. The supervisory input into the action plan and overall file management are also considered. This category is the most critical because it establishes the activity that is needed to move the case toward conclusion. It also is the category that most often is not in compliance.

Reserves. The financial reserves for both losses and expenses are based on the evaluation of the case from the beginning and can change throughout the life of the file. The reserve should accurately reflect the probable ultimate payment for the exposure. While reserve changes are inevitable, they should be done with a complete evaluation of the exposure and documented for the amount, thus eliminating frequent stair stepping of the reserve.

Negotiations/Disposition. Negotiations and disposition are the end result of the other categories, and a documented settlement plan is critical as it forces a good evaluation and aids in resolving the case for the most cost-effective amount. Settlement negotiations should be conducted timely and in most instances by the adjuster. When defense counsel is retained, the adjuster needs to manage the activity with the use of a documented litigation plan.

Customer Service. This category measures the timeliness of establishing the file upon receipt, responding to requests for information, the adherence to statutory requirements, and the timeliness of issuing payments. Also, compliance with special handling agreements and requesting authority are measured.

The audit process begins with a review of the organizational structure of the claim administrator and the special handling agreements. A loss run of open and closed files is the basis for the file selection. The selection should be random; however, an equal number of files should be selected from each adjuster handling your files. In most cases 10 percent of the open files and 5 percent of the closed files should be selected.

After the files are selected, the physical audit takes place at a central location. Individual audit forms are completed for each file selected. Completed forms are

provided to the claim administrator for feedback and reconsideration. The results are then compiled onto a spreadsheet where percentages of compliance are measured. These results will determine the strengths and weaknesses of the program. A comprehensive report should be prepared to document the results and develop an action plan for improvement with a timeline for measuring results.

Another type of audit is to review files only from a financial aspect. Any program that is loss sensitive will benefit from a reduction of over-reserved claims or files that are ready to be closed. If claims are not being monitored aggressively, a review of all open files can result in a reduction of 15 to 20 percent of the financial reserves. This process requires a review of all open claims and a discussion with the claim administrator on any reserve reduction or claim closure. The results are then summarized on a spreadsheet to determine the ultimate financial impact.

In conclusion, any program needs to be monitored for compliance to best practices. After establishing an initial benchmark of performance, annual reviews will determine the rate of improvement. If your claim provider is interested in keeping your business, he or she will take the necessary steps to improve. The documentation of the quality of your claim provider is a valuable tool in discussing the financial cost of your insurance program with senior management. If you are not auditing your claim provider, then you are not getting the best results out of your insurance program. ■

Advanced Alternative Risk Transfer Solutions

What You Need to Know about ART!

The Risk Management Section is proud to announce the debut of this exciting new education program! **Michael J. Moody MBA, ARM,** managing director of Strategic Risk Financing, Inc., will conduct a workshop in **Philadelphia on November 9, 2006**. A former risk manager and broker, Moody has been involved in insurance and risk management for more than 20 years. He is a frequent speaker and writer on various risk financing and enterprise risk management topics; and currently authors a monthly byline column on enterprise risk management in *Rough Notes* magazine.

What's It About?

The workshop will provide a comprehensive overview of the various alternative risk transfer mechanisms in use today. Now that the ART market makes up more than 50 percent of the commercial insurance marketplace, it is imperative that every insurance and risk management professional understand these solutions.

Who's It For?

This workshop is a must for all risk management and insurance professionals who are interested in the ART market and wish to understand it better.

Learning Objectives

At the conclusion of this workshop, the attentive learner will be able to:

- understand why the alternative risk transfer market is important
- identify the various segments of the alternative risk transfer market
- list the advantages and disadvantages of various alternative market solutions
- recognize competitive advantages obtained from the alternative risk transfer market
- understand how to use alternative risk transfer solutions for their customers

For additional information on this workshop, contact the CPCU Society Member Resource Center at (800) 932-2728, option 4.

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