

# business insurance

update

## Columbus Insurance Co. placed in rehabilitation

COLUMBUS, Ohio—The Ohio Insurance Department may have a buyer for troubled Columbus Insurance Co., which was placed in rehabilitation by the department Jan. 8 as a result of the insurer's "rapidly deteriorating financial condition."

William F. Rossbach, an examiner with the Ohio department, says the state has stopped all claims payments and is not allowing the company to

*Continued on next page*

Reporting weekly for corporate risk, employee benefit and financial executives/\$1.50 a copy; \$52 a year

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# Liquidation looms for Ideal

By JUDY GREENWALD

NEW YORK—The New York Insurance Department, which put Ideal Mutual Insurance Co. into rehabilitation less than a month ago, now says the company must be liquidated.

The department will seek a court order for Ideal's liquidation within the next few days, barring any "unforeseen circumstances," says a department spokesman.

Members of the department's liquidation bureau, which took over the insurer's operations after a New York Supreme Court judge ordered its rehabilitation Dec. 26, now believe "it's not a situation that can be rehabilitated," says the spokesman (BI, Jan. 14).

The department had said when it moved for rehabilitation that Ideal Mutual was \$155 million short of meeting its liabilities of \$310.6 million as of Dec. 31, 1983.

Ideal Mutual, formed in 1944 by National Dairy Corp., the predecessor of Kraft Inc., became an independent insurance company in 1972 and developed programs catering to corporate demands for alternative risk-funding products.

The insolvency of Ideal Mutual stems partly from Ideal Mutual's fronting programs for Bermuda-based captive insurers, partly from a pooling agreement with its affiliate, Optimum Insurance Co. of Illinois, and partly from increasing losses on business produced for it under managing general agent contracts, according to the New York department.

**'It's not a situation that can be rehabilitated,' explains a spokesman for the New York department.**

Not everyone agrees, however.

Ideal Mutual contends that its loss reserves are adequate, pointing to an actuarial study and the approval of its 1983 financial report by its certified public accountant.

And, one Ideal Mutual policyholder suggests the New York department could have avoided the rehabilitation.

While there was "no question" there was an impairment of capital, it was a "reasonably small fraction" of the amount alleged by the Insurance Department and "not nearly as black a picture" as presented, contends the policyholder, who asked not to be identified.

With a capital infusion of \$10 million to \$25 million, he said, the insurer would have been able to present a balance sheet that would be worthy of an "A" rating from A.M. Best Co. Then, Ideal Mutual would have been able to get back on its

feet and attract new business, he said.

Ideal was given a C-plus rating by Best in August.

Ideal Mutual's former president, B. Frederick Becker, said that the insurer's efforts to attract a \$30 million capital infusion fell through as a result of the Insurance Department's preliminary report on its triennial examination of Ideal. The report was released to Ideal Mutual while it was negotiating for the needed capital. Ideal Mutual had not expected the report until February.

The policyholder also said he believes there is an "element of truth" in some observers' belief that New York put Ideal Mutual into rehabilitation to serve as a warning to other insurers against providing corporations with fronting programs.

"I think the New York department has not liked the kind of operation Ideal has carried on for a number of years," he said.

In 1982, the New York department proposed a regulation that effectively would have outlawed fronting programs. Risk managers and insurers vehemently opposed it and it was never promulgated.

"If New York states as its purpose to restrict fronting, it could affect other insurers operating in New York and it also could affect the decisions and actions of insurance companies and regulators in other states," observed Duane Allen, who is a partner in the Laguna Hills, Calif., consulting firm of Ap-

*Continued on page 28*

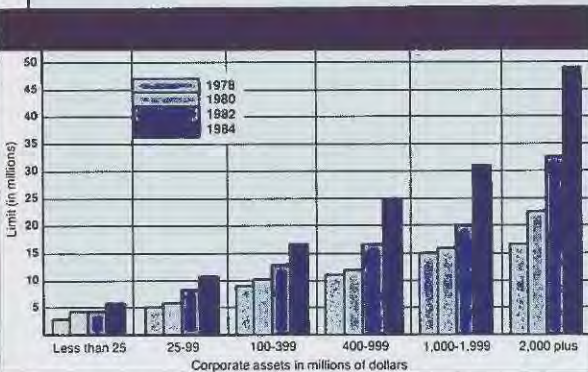
## Firms hiked D&O limits during 1984, study says

By STEVE TARAVELLA

CHICAGO—Faced with an increasing number of lawsuits against their directors and officers, more U.S. businesses have purchased more D&O liability insurance, according to a newly released survey by The Wyatt Co.

However, while the survey shows they have been able to purchase this additional coverage at bargain prices for the last couple years, it is clear that it will be impossible to repeat this feat in 1985.

Despite the pressure companies may feel to be more adequately protected against D&O lawsuits, the overall tightening of the commercial property/casualty insurance market in the seven months since the survey data was compiled has reduced the available limits and forced rates up



Graphic: Amy Palmer as much as 50% (BI, Sept. 3, 1984).

But, while the buyers' market continued into mid-1984, U.S. businesses looking for D&O insurance took advantage of it:

- About 8% more companies reported having D&O insurance in early 1984 compared with 1982.
- U.S. businesses last year increased their D&O policy limits by an average of 45% compared with 1982.
- Overall, companies paid about 24% less in premiums for D&O coverage in 1984 compared with 1982.

At the same time, businesses' exposure to D&O liability losses and the cost of the claims increased:

- The frequency of D&O claims increased an average of 10% in both 1983 and 1984.

*Continued on page 24*

## Insurers lobby Congress to cut pollution exposures

By ROBERT A. FINLAYSON

WASHINGTON—Property/casualty insurers want Congress to step in and absolve them of potential liability for billions of dollars their policyholders will be assessed to clean up abandoned hazardous waste sites.

They are considering lobbying Congress to convert the Superfund Act, which was established in 1980 to clean up abandoned waste sites, into a no-fault program funded by a broad-based corporate pollution tax.

Now, the insurers explain, policyholders held liable for cleanup costs paid through the Superfund are tapping their general liability policies to cover these costs. And, increasingly, both federal and state courts are agreeing that insurers must indemnify companies for these cleanup costs as well as damages they must pay for personal injuries caused by hazardous wastes.

Unless the law is changed, the insurance industry will pay the lion's share of the cost of cleaning up the thousands of hazardous waste sites around the nation, the insurers say.

The "unintended effect" of these court decisions, according to Dennis R. Connolly, a vp at the American Insurance Assn., is to "load Superfund cleanup costs on the insurance industry, which never intended to pick up these costs, never collected premiums for them and which didn't cause any of the pollution."

"We're up against the wall," said one official with a major liability insurer who asked not to be identified. "The specter of billions and billions in potential pollution liability" from both cleanup costs and personal injuries "threatens the solvency of any insurer that wrote general liability policies."

"I think we're beginning to realize that the industry has some potential liabilities out there that may well exceed the wherewithal of the industry," added another insurer executive.

"This is one of the key insurance issues, and may be one of the key social issues, of our time," remarked one more executive who also requested anonymity.

However, restructuring the Superfund Act would only relieve insurers of their liability for

cleanup costs for abandoned hazardous-waste sites and would not affect their obligation to indemnify policyholders held liable for third-party property damage or personal injuries. But, to limit these types of losses in the future, the most recent CGL forms proposed by the Insurance Services Office exclude coverage for both sudden and non-sudden pollution exposures.

To address the issue of cleanup costs, seven of the nation's largest property/casualty insurers have formed a Superfund working group.

Operating under the sponsorship of the AIA with Mr. Connolly as their official spokesman, officials from

Crum & Forster, Aetna Life and Casualty Co., Hartford Insurance Co., Travelers Insurance Co., Royal Insurance Cos., United States Fidelity & Guaranty Co. and CIGNA Corp. have been meeting regularly during the past two months to develop an alternative to the current Superfund law.

The Superfund Act is to be reauthorized by Congress this year; therefore, insurers say they must act now if they hope to have the law changed.

The Superfund is financed by a tax on the petrochemical industry only. And, the government is authorized to recover any money spent on cleaning up hazardous-waste sites from those re-

*Continued on page 4*



Graphic: Amy Palmer

## Employers' fiduciary liability claims also on the rise, report reveals

Page 25

NEWSPAPER

## update

## Insurer in rehabilitation in Ohio

Continued from previous page

write any new or renewal business until the department can assess Columbus' financial condition.

The insurer, which wrote \$4.2 million in primary and excess insurance for the first nine months of 1984, is about \$30 million "in the hole," Mr. Rossbach says. However, he says the company "possibly" can be saved, and, in fact, there are several potential buyers awaiting the department's report on the insurer's financial health.

Columbus Insurance Co. is licensed in 12 states and has written mainly nursing home professional liability insurance, he says.

## Ex-TPA officials plead guilty

LOS ANGELES—Two former workers compensation claims administrators accused of embezzling funds from numerous self-insured clients have pleaded guilty to a felony charge of conspiring to commit grand theft of more than \$100,000.

Larry K. Fitzpatrick, president of the now-defunct Fitzpatrick Self-Insurance Administrators Inc., and James E. Haggard, the company's secretary, entered the pleas Jan. 9 in Los Angeles Municipal Court, according to Dewain Barrett, investigator with the Los Angeles County district attorney's office.

The men, who will be sentenced Feb. 7 in Los Angeles Superior Court, could be sentenced to up to four years in prison, Mr. Barrett says. But, sentencing only resolves charges brought by Los Angeles County. The men are still subject to any charges brought by either San Bernardino or Orange counties, where other cities were allegedly victimized, he said.

The men vanished from their Upland, Calif., office on Aug. 16, 1982, and were apprehended by FBI agents in Fort Lauderdale, Fla., on Oct. 15, 1984 (BI, Nov. 5, 1984).

The embezzlements are believed to be the first in California involving an independent claims administrator and trust funds belonging to self-insured clients (BI, Sept. 13, 1982).

## Policyholders buy Aneco Mutual

HAMILTON, Bermuda—The approximately 75 policyholders of Aneco Mutual have purchased Aneco Risk Management Co. Ltd. and subsidiaries from Aneco Reinsurance Co. Ltd. for \$2.9 million.

The subsidiaries of Aneco Risk Management include Aneco Mutual Ltd., a rent-a-captive program; Aneco Marketing Co. Ltd.; and the brokerage Aneco Insurance Agency Inc. in Boston.

As a result of the transaction, privately owned Aneco Risk Management now owns about 20% of Aneco Reinsurance, a publicly traded company. Aneco Reinsurance's capital funds also are now increased by about \$3.5 million to \$8 million. Aneco Reinsurance Co.'s only subsidiary is now Aneco Reinsurance Underwriting Ltd., a reinsurer whose capital remains at \$10 million.

The management of the companies remains the same, with Francis J. Mulderig continuing as chairman of both entities.

## N.Y. malpractice rates hiked

NEW YORK—New York Insurance Superintendent James P. Corcoran has granted the state's medical malpractice insurers rate increases totaling 52% for the two most recent policy years.

The state's Medical Malpractice Insurance Assn., which was established by the legislature in 1975 and insures more than 900 physicians, has been allowed a retroactive rate increase of 41% for the 1983-84 policy year and an 8% increase for the 1984-85 policy year. The cumulative effect is a 52% increase over existing rates.

Mr. Corcoran said the same total increase of 52% will be granted to other medical malpractice insurers that submit revised rate filings for 1984-85.

Separately, a study by the American Medical Assn. has found a 20% increase in the number of medical malpractice claims filed in 1983 over the previous year, and a 33% increase in the value of malpractice awards between 1981 and 1983.

## High court to rule on RICO use

WASHINGTON—The Supreme Court has agreed to decide whether a federal law designed to help prosecutors fight organized crime can be used to sue corporations.

At issue is whether Congress intended the Racketeer Influenced and Corrupt Organizations Act (RICO) to be a vehicle through which corporations could be sued as "racketeers" and be forced to pay triple damages. The law allows lawsuits for damages incurred by individuals or businesses as a result of "a pattern of racketeering."

Such allegations have been made in lawsuits involving insurers, including litigation in Illinois brought by the Insurance Department

Continued on page 27

## N.Y. court decision strengthens insureds' right to defense cover

By STEPHEN TARNOFF

ALBANY, N.Y.—A decision by New York's highest court further strengthens policyholders' right to defense coverage.

In *Seaboard Surety Co. vs. The Gillette Co. and J. Walter Thompson Co.*, the New York Court of Appeals ruled that exclusions in a libel insurance policy did not negate Seaboard's obligation to defend Gillette and Thompson.

Attorneys in the case say that, according to the decision, courts will look only to the allegations in the lawsuit and to the language of the insurance policy when determining whether an insurer should defend a policyholder. They will not look at extrinsic facts to determine whether the insurer should defend.

As a result of last month's decision, New York-based Seaboard will have to reimburse Gillette and Thompson more than \$2.9 million in defense costs and interest incurred as a result of a suit against the companies by Alberto-Culver Co.

Alberto-Culver contended that the companies had made false statements about an Alberto-Culver product in a television commercial.

Yet to be determined is whether Seaboard will have to reimburse Boston-based Gillette and Thompson for a settlement of more than \$4 million reached with Alberto-Culver in 1979.

Also undecided is whether Seaboard is liable for tre-

ble damages because of its alleged bad-faith refusal to defend and indemnify Thompson and Gillette.

The insurance dispute arose when Alberto-Culver sued Gillette and Thompson over the airing of commercials that unfavorably compared an Alberto-Culver product with a Gillette product, Tame Cream Rinse. Thompson, a New York-based advertising agency, helped prepare the commercial.

Alberto-Culver, based in Melrose Park, Ill., contended that its product had been wrongfully portrayed and charged the companies with unfair competition, deceptive trade practice, consumer fraud, deceptive business practices and common law libel.

Seaboard conceded the allegations in the Alberto-Culver complaint were covered under a libel, slander, copyright, privacy, plagiarism and piracy liability policy that both Gillette and Thompson had purchased from Seaboard.

Each of the policies had a \$1 million limit but provided unlimited defense coverage.

Seaboard argued that policy exclusions negated its responsibility to indemnify Gillette and Thompson and that those same exclusions freed it from the duty to defend.

Under the policies, Seaboard agreed to defend and to pay all sums that the insured was obligated to pay as a result of any final judgment or money damages resulting from "libel, slander, defamation; any infringement

Continued on page 27

## 3 syndicates at Lloyd's face huge losses

By STACY SHAPIRO

LONDON—Members of three Lloyd's of London syndicates are facing the largest underwriting losses reported at Lloyd's since the Sasse Syndicate folded in 1978.

Syndicates 895, 898 and 899, all managed by Spicer & White (Underwriting Agencies) Ltd., report losses of more than 20.6 million pounds (about \$23 million) from 1980 through 1982, Spicer & White told the members last week.

The 250 members affected may have to pay up to 91,830 pounds (about \$102,849) if they wrote 20,000 pounds (about \$22,400) of premium in each of the three years, according to a report prepared by the agency.

And, the members may be asked to pay even more, Spicer & White warned, because the strength of the U.S. dollar against the British pound is increasing the size of unpaid claims and more claims may be received.

The losses stem in part from North American business produced by U.S. managing general agencies that had binding authority for the syndicates, says Spicer & White.

Continued on page 27

## North American Re says it still writes casualty risks

NEW YORK—Contrary to some reports, North American Reinsurance Corp. is not pulling out of U.S. casualty business, says President N. David Thompson.

A statement by the chairman of Zurich-based Swiss Reinsurance Corp., the owner of North American Re, that Swiss Re will no longer reinsure "heavy liability risks under established conditions" in the United States reaffirms established policy at its U.S. subsidiary, Mr. Thompson says.

At the same time, a spokesman for Swiss Re in Europe said Swiss Re's policy against reinsuring heavy casualty risks in the U.S. applies to its operations around the world. While other Swiss Re subsidiaries do not directly reinsure U.S.-based insurers, they can be exposed to U.S. risks by reinsuring exporters to the United States.

In the United States, "North American Re has been very selective as to major or heavy casualty business for some time," Mr. Thompson said. "And, there is therefore no dramatic change in our business from 1984."

"We continue to look at a broad spectrum of casualty on a facultative basis and have every intention of maintaining a significant book of casualty treaty business," Mr. Thompson said. This includes comprehensive general liability, auto liability, all personal lines, light commercial risks and so-called Main Street business.

"There's been no change in our policy on this kind of business," Mr. Thompson said.

North American Re began in 1980 to increase its reinsurance prices and tighten terms on major liability lines and as a result started losing casualty business to competitors, Mr. Thompson said.

Mr. Thompson acknowledged that some surplus lines casualty business written by North American Re in 1984 would not be written in 1985, but stressed that this is not a change in the company's underwriting posture.

Noting that it is impossible to precisely define "heavy casualty" or

Continued on page 8

## Lloyd's may consider using U.S. dollar as base currency

By STACY SHAPIRO

LONDON—Lloyd's of London should consider using the U.S. dollar as its base currency rather than the British pound, recommends a recent report by a Lloyd's working party.

The strength of the dollar against the pound is limiting the capacity that Lloyd's syndicates can write, notes Lloyd's Chief Executive Ian Hay Davison.

Although Lloyd's overall capacity in pounds has risen about 25% to 5.2 billion pounds from 4 billion pounds in the last year because of increased membership, the value of the pound to the dollar has declined about 23% to the current \$1.12 from about \$1.45 a year ago.

Thus, there has been little increase in the capacity that Lloyd's can write in dollar terms.

About 50% of Lloyd's premium volume is written in dollars rather than pounds, and most of its aviation and marine business is written in dollars.

The capacity crunch caused by the pound's weakness

is occurring at a time "when rates are hardening, orders are increasing and the world's capacity is short," Mr. Davison noted.

The recommendation to review Lloyd's currency base is in an addendum to a document on membership requirements written by a working party chaired by Patrick Bird, a member of the Lloyd's Council and a director of R.J. Kiln & Co. Ltd.

The party recommended that, "a separate study should be made into the possibility of switching all of Lloyd's trading from a sterling base to a U.S. dollar or basket of currencies base."

Most of the report deals with a review of the requirements governing Lloyd's members.

Although the Lloyd's Council has not yet accepted the entire report, it has agreed on two points contained in it, noted Mr. Davison.

Lloyd's members will continue to have unlimited liability for losses, "our biggest form of security," said Mr. Davison.

Continued on page 22

## index

Ask a benefit manager	20
Benefit beat	14
Classifieds	26
Comings&goings: buyers	11
Comings&goings: industry	16
Info	10
Insurance services guide	28
Letters	6
London line	13
Markets	12
Opinions	19
Perspectives	6
Ticker	29

Vol. 19, No. 3—*Business Insurance* (ISSN 0007-6864) is published weekly at 740 Rush St., Chicago, Ill. 60611. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, circulation department, 740 Rush St., Chicago, Ill., 60611; 312-649-5221. Copyright 1985 by Crain Communications Inc.

# Employer considers refund of health plan contributions

By DIANE LYNN KASTIEL

FAYETTEVILLE, N.C.—A small North Carolina utility thinks refunding health plan contributions to employees whose annual claims total less than their contributions may help cut health care utilization.

The utility has yet to introduce the plan, but the idea is reopening the debate among employee benefit consultants and employers over the usefulness of refund plans in controlling health care costs. Consultants contend refunds are not the best way to cut utilization and could end up costing the employer more than they save.

The refund program under consideration at North Carolina Natural Gas Corp. in Fayetteville, is the brainchild of William L. Aycock, the company's personnel director.

Under Mr. Aycock's plan, the company would refund to each of the company's 430 employees the difference between the employee's contributions and paid claims if claims do not exceed contributions.

The company has not yet decided if it will adopt the plan. Employees currently pay 40% of the cost of the self-insured plan, while the company pays the other 60%. Employees with individual coverage now contribute \$28.91 a month; family coverage costs \$60.12 a month.

A small portion of those contributions also pays for life and accidental death and dismemberment insurance, Mr. Aycock notes.

In addition, employees must meet a \$150 individual and \$450 family deductible and pay 20% of expenses over the deductible, up to a maximum out-of-pocket cost of \$1,000 per person.

Mr. Aycock says the plan is a response to a 47% increase in employee contributions in the last 2½ years. In addition, in July 1982, deductibles were hiked by 50% and coinsurance levels were raised to 20% from 15%.

"It was a triple whammy," Mr. Aycock said. "When the premiums were increased 50%, you can imagine the employee relations problems we had. We wanted to do something that would make it more fair and make them feel as if we were doing something for them."

Mr. Aycock says the proposal is intended to give employees an incentive to use health care frugally and to create equity between what employees put into the plan and what they get out of it.

But, despite the advantages cited by Mr. Aycock, consultants say the plan's loose strings could tie the company into a knot.

"It's a basic principle of insurance that there are winners and there are losers," said Peter Hutchings, partner at Kwasha Lipton in Fort Lee, N.J. "And the losses of the losers pay for the claims of the winners. In the typical year, most employees don't use a lot of health care and a few employees hit it hard. And when that happens, you have that... problem."

Other consultants balk at what they interpret as a system that pays people not to seek medical care.

"It's counter to the insurance concept, but, more importantly, it puts so much pressure on people not to spend money (on medical care) in order to get the cash," said David L. Glueck, vp and manager of U.S. group benefits for Towers, Perrin, Forster & Crosby in New York.

"That's an inappropriate way to design a plan. People should not have that much of a financial stake in what is an insurable item," he added.

"It's counterproductive to long-term health care cost containment because you want people to go to the doctor when the problem is small rather than wait until the problem is serious and more expensive," according to Fred Schick, a principal at A.S. Hansen Inc. in Chicago.

Continued on page 22

# No snow job

## Basic loss control pays off in San Antonio

By ROBERT A. FINLAYSON

SAN ANTONIO, Texas—If Mother Nature dropped more than a foot of snow on Chicago, Minneapolis or Boston, it would probably be considered little more than a nuisance.

But in ordinarily balmy San Antonio, 16 inches of snow can be an abominable risk management problem.

The city has no snow removal equipment and little experience in dealing with snow. Therefore, last week's snowfall, which the National Weather Service labeled the worst in 100 years, could have resulted in a substantial number of traffic and other types of accidents.

To prevent that, San Antonio Mayor Henry G. Cisneros asked the city's businesses and schools to employ a time-honored risk management technique: risk avoidance. The city then virtually shut down on Jan. 14.

"The mayor's plan ran like a top," says Scott Wyatt, risk manager for San Antonio. "There were very few accidents because the mayor closed the major highways and asked people to stay home."

To encourage people not to drive if they had to venture out, the city's bus system operated free of charge, a spokeswoman for the mayor's office said. Then, with the highways clear of automobile traffic, the city borrowed construction equipment to scrape the snow off the highways, she added.

A local branch of GAB Business Services Inc., a claims adjusting company, noted that no major property or liability claims had been reported as a result of the snowfall.

Most employers complied with Mayor Cisneros'

request that workers be told to stay home, risk managers reported last week.

"We chose to avoid the situation" and close, said Gonzalo Ornelas, risk manager for H.B. Zachry Co., a San Antonio-based general contractor. "A lot of people were not in their offices Monday," he noted.

Mr. Ornelas suggested that a good risk management technique was to remain at home and build snowmen.

Other area businesses took similar action.

Ron Denny, a vp with H.E. Butt Grocery Co., said the company's San Antonio stores reduced their hours so that many employees could stay home. Mr. Denny also said the company was able to equip enough of its trucks with chains to get milk and bread to its stores and added the company reported no accidents.

Two national banks in San Antonio did close Jan. 14, a move that required the permission of the U.S. comptroller of the currency. The Frost National Bank was, appropriately enough, open, said Josie Lozano, the bank's risk manager.

Ms. Lozano said that in spite of the snow, the bank was fairly busy. None of its employees or customers reported any accidents.

"I think people were extra careful," she explained.

Ms. Lozano noted the bank does not have a contingency plan for a snow emergency. "We have one for everything else. Civil disturbances. Hurricanes. Everything. But not snow," she quipped.

The city's risk avoidance program was short-lived, however. Temperatures reached 45 degrees in San Antonio on Jan. 15, which melted much of the snow and allowed businesses to resume normal operations.



Photo: Wide World

People stayed home, but a snowman paid a visit to the Alamo last week.

# Abortion clinics lose coverage after attacks

By STEVE TARAVELLA

Many facilities that perform abortions are having a hard time keeping their property/casualty coverage following a wave of attacks on abortion clinics across the nation.

At least one clinic was forced to close when the property and general liability insurance for both the clinic and its landlord was canceled.

Other clinics that have been the target of attacks by pro-life activists say insurers have either canceled or decided not to renew their coverage. They add that finding replacement coverage can be difficult and very expensive.

"It's going to be difficult" for clinics to find insurance, says the director of one clinic that was bombed last year. "I spent many an hour being turned down."

Insurers note they are canceling coverage because the centers are poor risks, not necessarily because abortions are performed at the facilities.

"I guess if someone was out there bombing pizza parlors, we'd be more careful about how we wrote them, too," said an underwriter who asked not to be named.

Twenty-nine facilities that perform abortions were the target of bombings or arson last year, including three separate incidents on Christmas Day. Four clinics were hit in 1983, and at least one attack has already been reported this year.

In addition, authorities are warning clinics to be prepared for more violence this week. Tuesday marks the 12th anniversary of the Supreme Court decision that legalized abortions nationwide.

Finding insurance "is definitely becoming a bigger problem. We've heard from several clinics that have been notified that they won't be renewed," says Lois Schoenbrun, membership director of the National Abortion Federation in Washington, an 8-year-old organization whose members include about 300 institutions and 175 individuals that perform abortions.

The inability to find insurance led to the closing of the Feminist Womens Health Center in Everett, Wash. The center, which leased space in a building owned by a local bank, was hit by arsonists three times in two years.

After the first fire on Dec. 3, 1983, SAFECO Insurance Co.

**'I guess if someone was out there bombing pizza parlors, we'd be more careful about how we wrote them, too,' says an underwriter.**

of America issued a 30-day cancellation notice for the business owners policy it wrote for the center, says Beverly Whipple, the center's executive director.

The policy included premises liability coverage with a \$1 million per-occurrence limit; business interruption coverage equal to actual losses sustained for up to 12 consecutive months; and contents replacement coverage with a \$30,000 limit.

That coverage, which cost the center about \$300 a year, was placed by D.A. Duryee & Co. Inc., an Everett broker.

"We did not cancel the coverage because we have a problem with abortion clinics; the problem is with arsonists," says Richard Michela, property manager for Seattle-based SAFECO. "It was predictable that they would be bombed again. It was a pure business decision."

SAFECO has paid more than \$100,000 in claims stemming from the Everett fire and another attack at an unaffiliated clinic in Bellingham, Wash. that SAFECO covered, Mr. Michela estimates.

In February 1984, the Everett center purchased a package policy similar to the SAFECO package from London-based Terra Nova Insurance Co. Ltd. The Terra Nova package, which had lower limits but cost almost three times as much as the SAFECO coverage, was placed by Junker, Shaw Insurance Agency in Yakima, Wash.

"It's obvious to those underwriting that the chances of an-

other bombing or fire are pretty apparent. Companies are just not willing to write the risk at a standard rate," says Barbara Shaw, an official at the agency.

The new policy provided liability limits of \$500,000 per occurrence and \$500,000 annual aggregate; property coverage of up to \$30,000 at actual cash value, not replacement value; and business interruption coverage of \$1,500 per month for up to three months, a maximum of only \$4,500.

The clinic was hit by arsonists two more times—on March 26 and April 19, 1984. After the April fire, Terra Nova canceled its coverage.

Obtaining replacement coverage was no longer a concern to the clinic, however. When the building's landlord, Olympic Bank in Everett, also lost its property and general liability coverage on the building because of the attacks, it canceled the center's lease.

The Everett clinic has not operated since.

Olympic Bank's insurer, Aetna Casualty & Surety Co. in Hartford, Conn., did not renew the bank's coverage on May 2, according to Gordon Shewfelt, a trust officer at the bank.

The bank's broker, Johnson & Higgins in Seattle, tried to find coverage for the building with many underwriters. Mr. Shewfelt says. "But as long as we retained the clinic in the building, we could not find insurance with anybody."

While the bank is still seeking a new tenant, Mr. Shewfelt notes that "another clinic will not be put in there."

Coverage for the bank building was written from May to November by St. Paul Mercury Insurance Co. and Lloyd's of London underwriters, but that coverage, with a \$6,000 premium, was too costly to maintain permanently, he says.

The bank finally obtained permanent coverage as a result of its merger with First Interstate Bank of Washington. First Interstate's broker, Fred S. James & Co. Inc., obtained coverage for the building under First Interstate's blanket policy, underwritten by Los Angeles-based Truck Insurance Exchange, Mr. Shewfelt says.

The Everett incidents affected the coverage for another branch of the Feminist Womens Health Center in Yakima, Wash., even though it has never been attacked.

Philadelphia-based General Accident Insurance Co. of

Continued on page 27

# Insurers ask for change in Superfund law

Continued from page 1  
responsible for the pollution.

The insurers are proposing that Congress eliminate this assessment of liability for pollution and replace it with a no-fault system funded by a broad-based pollution tax on most U.S. businesses, possibly excluding companies with less than \$5 million in annual sales.

Members of the AIA group contend that, if the tax is broad enough, the cost would be insignificant to individual companies. They also are promoting a no-fault system to eliminate the costly and time-consuming legal battles that are sometimes necessary to force responsible parties to pay for site cleanups.

The most recent study by the U.S. Environmental Protection Agency puts the cost of cleaning up

the toxic chemical dumps that dot the American countryside at more than \$22 billion, based on an estimated cost of \$8 million each for 2,500 known problem sites.

But the EPA says there may be as many as 300,000 sites that could be candidates for Superfund cleanup action in the future.

"For the Shell Oil Co. cleanup suit on the Rocky Mountain Arsenal, they're talking about serious settlement costs between Shell and the government in the neighborhood of between \$300 million and \$500 million," Mr. Connolly said.

Shell is suing about 270 of its general liability insurers over coverage of the settlement. The case is under consideration in the U.S. District Court in San Francisco where Shell's insurers have filed a motion asking the court to dismiss

A study group member says, 'Never underestimate the creative ability of desperate people.'

the case (BI, Nov. 28, 1983).

"You've got Love Canal at \$20 million, and there are other cases that are in that magnitude of dollars," Mr. Connolly continues. "That is something seven years ago nobody dreamed of in their wildest imagination. And, suddenly within the past year, they're becoming real dollars. That's the kind of thing that gets people's attention," he adds.

The problem for insurers is further complicated by the fact that under CGL policies, insurers owe a defense to each of their policyholders named in a Superfund lawsuit—at least until the insurers can prove there is no coverage under their policies for this type of liability.

"If we win a lot of these cases, the costs are going to be big (because of the defense costs), but if we lose a lot of them, the costs are going to be extraordinary," explains one member of the AIA Superfund group.

Mr. Connolly argues that because everyone benefited from the chemical products manufactured over the past 40 years, everyone should pay to clean up the resulting wastes.

"It's abundantly apparent to me that a system that loads all of the

cleanup costs on non-polluting insurers is not an equitable system," Mr. Connolly concludes.

However, AIA group members admit chances are slim that Congress will consider their plan.

"This may turn out to be the biggest laugh of the 99th Congress," says one member of the group. However, he adds, "There aren't many alternatives for the industry."

"You either get some relief in the federal legislative process by recasting Superfund or you just slug it out in the courts day in and day out, hoping you win more than you lose."

Congressional staffers familiar with the Superfund program also have doubts that the insurers' proposal will carry any weight in Congress. They say the proposal goes against the basic premise in the Superfund law that "the polluter pays."

The staffers add that they expect the current liability provisions in the Superfund law to be strengthened, not weakened, during reauthorization.

Mr. Connolly says the AIA study group probably will decide in the next few weeks whether it will introduce its proposal on Capitol Hill.

Meanwhile, the AIA group is wrestling with the problem of how to communicate to Congress how serious the problem will be if property/casualty insurers are held liable for the bulk of the hazardous waste site cleanups.

Most members of the Superfund study group say their companies would be very reluctant to release claims data, even as part of a lobbying effort. Others add that they can't even get the information about pollution claims from their companies' claims department.

"I still don't know what our potential liability is in real hard terms for asbestos, for example, and we've been into that for years," one official said.

There is a "real resistance" in his company's claims department to generate these numbers "because once you know them, they're discoverable in legal cases."

Members of the group admit that without hard evidence that pollution cleanup claims will harm the insurance industry financially, Congress will find it difficult to accept the industry's argument that the Superfund law should be changed radically.

However, one member of the Superfund study group points out the insurance industry lobby was successful last year in thwarting an attempt to put a federal cause of action in the Superfund law, which would have allowed citizens to sue polluters in federal court using the law's strict liability provisions.

"Never underestimate the creative ability of desperate people," another Superfund study group member said.

But even if the insurance industry is unable to persuade Congress to change Superfund, insurers may yet receive some relief from the courts.

In an amicus curiae brief filed in *U.S. vs. Northeastern Pharmaceutical and Chemical Co. Inc.*, attorneys for Syntex Agribusiness Inc., an agricultural concern based in Verona, Mo., contend that application of Superfund's liability provisions to actions that occurred prior to the law's enactment in December 1980 constitutes a denial of due process of law.

The case is being heard before the 8th U.S. Circuit Court of Appeals, and if the court agrees with Agribusiness' position, it would relieve companies in the 8th Circuit, and consequently their insurers, of liability for much of their past disposal practices. ■

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## opinions

# Too many questions

THE REHABILITATION and now possible liquidation of Ideal Mutual Insurance Co. by the New York Insurance Department leads us to one of two conflicting conclusions:

Either the New York Insurance Department has failed to adequately regulate Ideal Mutual.

Or, the New York Insurance Department was overzealous in its latest examination of Ideal Mutual and needlessly drove it into rehabilitation.

Either way, it appears that the New York department has not fulfilled its responsibility to protect the policyholders of Ideal Mutual.

We cannot determine which conclusion is correct—or offer one that is more generous to the New York Insurance Department—because we have too many unanswered questions.

Question: How can the examiners for the New York department find Ideal Mutual's loss reserves inadequate if actuaries Tillinghast, Nelson & Warren certified them as adequate?

Of the \$155 million insolvency, about \$35 million is attributed to inadequate loss reserves.

Question: Why did the New York department wait until Ideal Mutual's 1983 triennial examination to disallow credit for reinsurance with its affiliate Optimum Insurance Co. of Illinois? The New York department obviously knew of the reinsurance pooling agreement.

Of the \$155 million insolvency, about \$60 million is related to this pooling agreement.

Question: Is there any real possibility that the major corporate policyholders of Ideal whose risks have been reinsured with their own insurance subsidiaries would not reimburse Ideal for all claims paid on their behalfs? Is this merely the New York department ex-



pressing its displeasure with fronting programs?

Of the \$155 million insolvency, about \$60 million is related to these fronting programs.

Question: Why didn't the department follow up on its 1980 examination of Ideal Mutual if in fact it found "problems," as a spokesman said.

Question: Why did the department announce to Ideal Mutual the preliminary results of its triennial examination at the time Ideal Mutual was on the verge of successfully negotiating a \$30 million capital infusion?

When we learn the answers to these questions, we may reach another conclusion.

## letters

### Chinese insurer helpful in dealing with foreign clients

To the editor: The article by S. Robert Beane, "China: A New Challenge" (*BI*, Dec. 3, 1984) about China and the People's Insurance Co. of China, was a good summary of the current conditions.

Indeed, I agree with his statement that "the PICC is sincerely interested in accommodating the needs of large foreign clients," and I can state from personal experience that its subsidiary, the Ming An Insurance Co. in Hong Kong, is particularly receptive and accommodating to foreign brokers.

A couple of years ago, one of our multinational clients was contemplating the construction (through a joint venture) of a plant in one of the economic zones that would require a combination business interruption and extra-expense cover.

Because of the differences in operation that were contemplated at that location, as opposed to elsewhere in the world,

there obviously were aspects of the coverage that required special attention.

I made various visits to the Hong Kong office and was received most cordially.

I had been told by various sources that it was an unlikely cover for them to write, since it was not normal to the China insurance trade and that I probably would have a poor reception.

Quite to the contrary, I was delighted with the cooperation that was offered and extremely surprised and pleased to find acceptance of our wording granted from the parent, back through the Ming An in Hong Kong, in less than 30 days.

Although I was without the use of an interpreter, communication was not a problem, and the company's understanding of what we were attempting to accomplish was very comprehensive and timely.

For those of my contemporaries con-

templating negotiations with Ming An, I can heartily recommend the company's staff as fine people with whom to deal.

**Charles R. Adams**  
President  
Adams & Sons Inc.  
Auburn, N.Y.

### California group works to change tort system

To the editor: In response to your editorial, "Don't Pass Up a Chance to Be Heard" (*BI*, Nov. 26, 1984), commenting on Ellis Horvitz' remarks about the need for insurers to participate more actively in an amicus curiae capacity before the appellate courts, your readers should know that the Assn. for California Tort Reform has increasingly become active as an amicus in a number of cases before the California Supreme Court, with favorable results.

The ACTR is a non-profit corporation composed of more than 60 members from business, the professions and utilities, including a number of insurers, which is trying to bring greater efficiency, fairness and economy to our tort laws.

We welcome insurers and others who are not members to join with us and seek reform of our civil justice system through legislation and appellate court review.

**Fred J. Hiestand**  
Counsel  
Assn. for California Tort Reform  
Sacramento, Calif.

■ ACTR's address is 1130 K St., Suite 250, Sacramento, Calif. 95814; 916-442-1111.

*Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.*

### DRGs may create new kinds of problems

To the editor: There is another side of diagnostic-related groups and cost-containment issues (*BI*, Dec. 24-31, 1984).

My mother, age 76, has been quite sick for a year or so, and in late summer 1984 she went to a nursing home following another hospital stay. Among other problems, her brain deteriorates by the week, she gets recurrent infections, falls and has had several strokes.

Six weeks ago she had the worst stroke, and we were certain she would die, but somehow she recovered. With some paralysis and speech impediment, she was quickly sent back to the nursing home. On Dec. 27 at 3 a.m., the nursing personnel discovered her blood pressure had elevated substantially, and she was sent to the hospital again.

Although we don't know, it appears the DRG was for an infection. But, she has substantial pain each day, is completely disoriented, is not eating, and others are unable to comprehend what she says.

On Monday, Dec. 31, the hospital threw

her out again, back to the nursing home. Her regular doctor, who is on vacation, still hasn't seen her, and whoever is caring for her hasn't seen much of her anyway.

The bureaucratic maze between the doctor, the DRG regulations and the hospital people to whom DRG enforcement is delegated is practically impossible for a 76-year-old husband who loves his wife to figure out, and his 40-year-old son isn't doing much better.

We aren't the type of people to start lawsuits, but we know a lot of people who will. Based on personal experience and more than 20 years of writing professional liability insurance, I believe that the savings from the use of DRGs will look very small compared with the judgments and settlements unhappy people will pursue in the future.

**Edward H. Akin**  
President  
Akin-Akin Inc.  
Howell, Mich.

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Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 25-4248, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 604207 CRAIN COM NYK; Suite 814, National Press Building, Washington, D.C. 20045; 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 20-22 Bedford Row, London WC1R 4EB, England. \$1.50 a copy. \$52 a year in U.S. Canada and all other foreign add \$16 for surface mail. Europe and Middle East only add \$45 for air delivery. First-class mail to U. S. and Canada only, add \$48. Bermuda only, \$97 per year expedited delivery. WILLIAM STRONG, vp-circulation. ROBERT FIORITO, circulation manager. ROGER DIGREGORIO, fulfillment director. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 740 Rush St., Chicago, Ill. 60611, or phone 312-649-5221. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229.



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## North American Re not leaving market

*Continued from page 2*

"major casualty" risks, Mr. Thompson said generally North American Re defines these as major environmental and product liability exposures and professional liability.

"We have been reducing that business for quite some time," Mr. Thompson said.

In addition, North American Re has never been a large reinsurer of medical malpractice and directors and officers liability risks, which also generally are considered heavy casualty risks.

Casualty business, which in 1980 had been about 40% of North American Re's business, was down to about one-third of its business in 1984. Casualty risks will be about one-third of North American Re's business this year, Mr. Thompson said.

North American Re wrote an estimated \$480 million in net premiums in 1984, and Mr. Thompson is

projecting about the same volume during 1985.

Reports that North American Re had pulled out of U.S. casualty risks apparently have been based on a portion of the statement by Swiss Re Chairman Walter Diehl in Swiss Re's November 1984 report to shareholders. Mr. Diehl said, in part:

"Compelled by this critical situation in North American liability business, the Swiss Re is giving up the reinsurance of heavy liability risks from this market on the established basis, as partial measures, taken over a number of years, have not met with the expected success and because the data used to assess risks and calculate premiums has become insufficient and increasingly questionable."

This statement followed Mr. Diehl's discussion of liability claims development in the United States, in which he said:

"The claims development in North American liability business (particularly products liability and environmental impairment) placed a heavy burden on the account of the report year. Here factors not belonging to this period had a particularly pronounced effect on the results as substantial reserves had to be allocated for claims made in 1983 but the causation of which often lay many years in the past.

"Claims, and particularly late claims, which in Europe would be considered exaggerated, are repeatedly being brought with success before American courts of law. The lawyers' remunerations can reach a very substantial percentage of the amount awarded."

Mr. Diehl also commented that asbestos claims soon will pose a "great burden" on American and international insurers.

Mr. Thompson noted that North American Re would consider writing heavy casualty risks again if the reinsurer's liability for the risks could be better controlled.

"It's questionable whether rates alone can respond to the problem," Mr. Thompson stressed.

Under current reinsurance contracts, "the distribution of risks in some casualty lines has become unbalanced. Reinsurers are being asked to take a disproportionate part of the risk of enormous and unknowable future losses.

"Recent large toxic tort and environmental losses are only examples," Mr. Thompson continued. "Meanwhile, the casualty tail is getting longer and the expansion of liability concepts continues."

Rather than only increasing prices, Mr. Thompson suggests that "insurers and reinsurers have to cooperate in developing new methods and forms that get these risks into acceptable time frames and proportions. That's what the Swiss Re is saying and I think that any reinsurer who takes a long view of the future will agree." ■

## North-West ruling

PORTLAND, Ore.—A Circuit Court judge agreed last week to give a group of Louisiana employers and agents 60 more days to complete their plan to keep intact business underwritten by North-West Insurance Co., which was placed in liquidation Dec. 4.

The group wants to create a new insurer in Louisiana by spinning off the book of business written by Mid-Continent Underwriters Inc. in New Orleans. This new insurer would immediately be placed in rehabilitation in Louisiana (BI, Dec. 24-31, Dec. 10, Nov. 5, 1984).

The bulk of Mid-Continent's business was written in Louisiana's oil patch. By spinning off the business, the group hopes to collect from North-West's reinsurers on workers compensation, marine and general liability policies. ■

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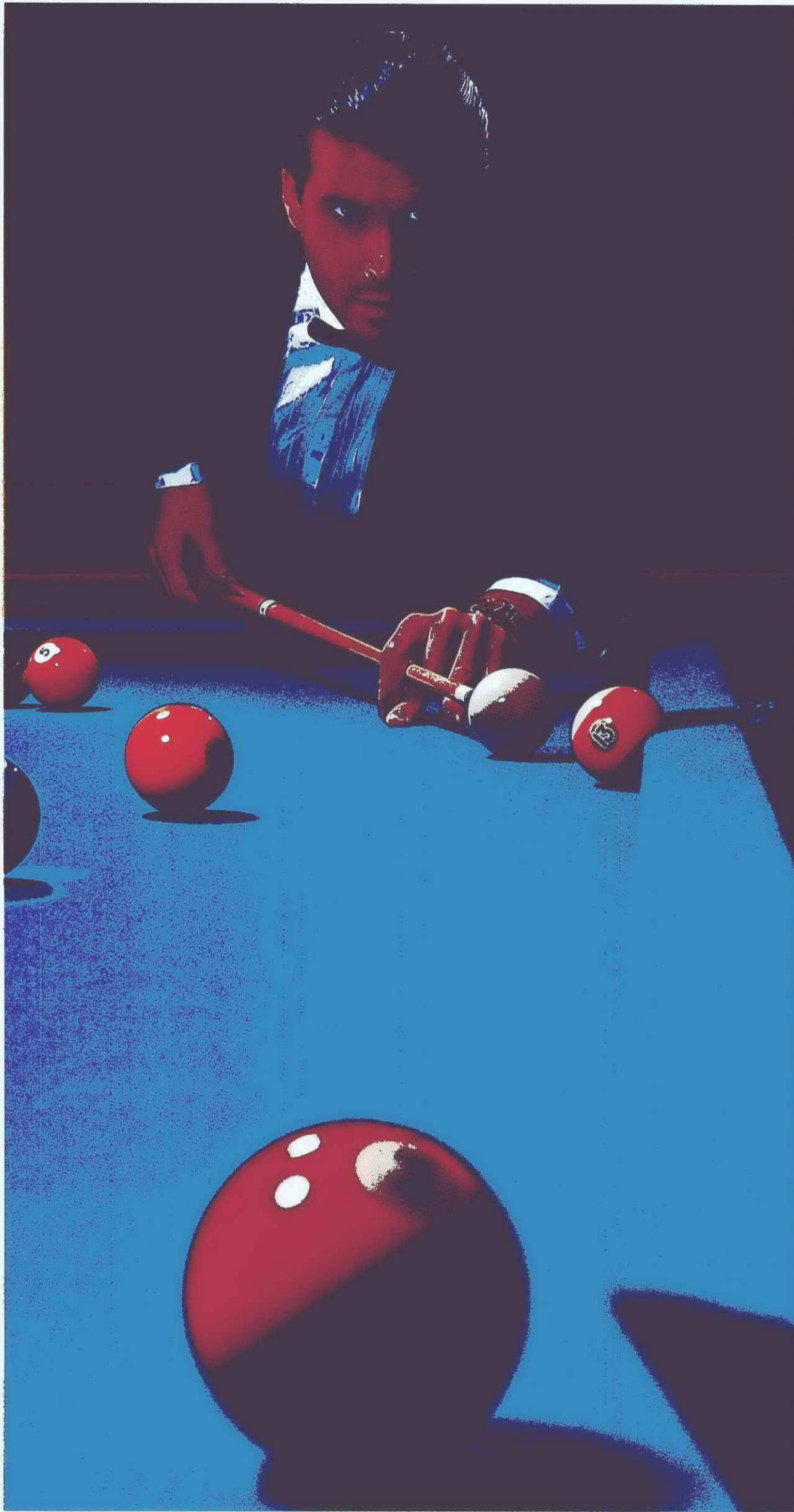
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• "Product Liability Guide for Manufacturers" written by manufacturers and attorneys especially for those responsible for the **product liability** claims process from the initial claim notice to the final settlement is now available from the Hand Tools Institute. The 20-page publication helps the reader

avoid unnecessary costly settlements and aggravation. To order, send \$3 to the Hand Tools Institute, 25 N. Broadway, Tarrytown, N.Y. 10591.

• "Health Insurance and Other Employee Benefits in the United States" is a 14-page brochure outlining the basics of **health insurance and other standard benefits**. It is available from the Blue Cross & Blue Shield Assn., and a free copy may be obtained from Theresa Duff, Consultant, Market Development & Planning, Blue Cross & Blue Shield Assn., 676 N. St. Clair, Chicago, Ill. 60611.

• The "1985 Safety Management Seminars, Consultations and Training Products" catalog is available from the International Safety Academy. Focusing on the academy's full range of services, the major topics include **safety program management, property protection and occupational safety and health**. For a free copy, call the ISA at 1-800-231-4302, or 215-241-4302 in Pennsylvania.

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• Increasing interest in the property/casualty insurance industry and changing regulations in the financial services area is focusing more attention on the **accounting practices and taxation of insurers**. "Basic Concepts of Accounting and Taxation of Property/Casualty Insurance Companies," published by the Insurance Information Institute, shows what to look for when reviewing an insurer's financial statements. The cost is \$10 for members and \$20 for non-members. It is available from III, Publications Service Center, 110 William St., New York, N.Y. 10038; 212-669-9200.

• A complimentary 20-minute cassette on the **"International Safety Rating System"**—what it is and how it can identify the major loss exposures of your organization—is now available from the International Loss Control Institute. Learn how to protect your people, property, process and profits. To order, write ISRS Cassette, ILCI, Highway 78, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208.

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# Crown Zellerbach names Mathison benefits director

Linda Mathison, 43, has been promoted to corporate director of employee benefits for Crown Zellerbach Corp., a wood products manufacturer in San Francisco. In this newly created position, Ms. Mathison is responsible for the design, communications and financial and administrative management of the company's employee benefits plans. She reports to Tod Spearling, vp of human resources. Previously, Ms. Mathison was manager of benefits administration. She received a bachelor of science degree in business administration from the University of California at Berkeley in 1963. She is a trustee of the Council on Employee Benefits.

James E. Pettis, 32, has been promoted to vp of risk management for Golden Nugget Inc. in Las Vegas, Nev. In this newly created position, Mr. Pettis is responsible for litigation management, claims administration, negotiation of insurance programs, employee benefits, risk financing and loss control. He reports to Clyde Turner, executive vp and chief financial officer. Previously, Mr. Pettis was the company's director of corporate insurance and safety; he will retain his previous responsibilities in his new position. He received a bachelor of science degree in finance from the University of Nevada, Las Vegas, in 1977.

Marilyn H. O'Keeffe, 34, has been appointed assistant director of risk management at Reliance Electric Co. in Cleveland. In this newly created position, Ms. O'Keeffe is responsible for administrative department functions with specific responsibilities in the areas of systems, expense planning and cost accounting. Previously, she was the company's manager of financial planning analysis. She reports to Ronald H. Stolle, director of risk management. Ms. O'Keeffe received a bachelor of science degree in accounting from Miami University of Ohio in 1971 and a master's degree in business administration from John Carroll University in Cleveland in 1983. She also is a Certified Public Accountant.

Also at Reliance, Victoria I. Fairman, 35, has been promoted to risk manager. In this newly created position, Ms. Fairman is responsible for all property and casualty risks, with special emphasis on claims and loss prevention. She reports to Ms. O'Keeffe. Before her promotion, Ms. Fairman was manager of insurance administration. She received a bachelor of arts degree in psychology from Northeastern Illinois University in Chicago in 1971 and is currently studying for a master's degree in business administration at Case Western Reserve University in Cleveland. She also holds the Associate in Risk Management designation.

Rosanne M. Bills, 28, has been named benefits financial analyst at Reliance. In this newly created position, Ms. Bills will manage the company's insured benefits management system. She also will

## comings & goings: buyers

report to Ms. O'Keeffe. Previously, Ms. Bills was the company's finance coordinator. She is working toward a Certified Employee Benefits Specialist designation.

Joseph V. Yandoli, 54, has been elected an assistant treasurer of Columbia Gas System Service Corp. in Wilmington, Del. In this newly created position, Mr. Yandoli is responsible for managing the financial aspects of the company's risk management department and will continue with his previous responsibilities as director of risk management. He reports to Stanley C. Kauffman, vp and treasurer. Mr. Yandoli received a bachelor of science degree from Rutgers University in 1959 and also has attended Dartmouth Graduate School of Credit and Financial Management and The College of Insurance in New York.



Mr. Yandoli

Reporting to Mr. Yandoli at Columbia Gas System is Raymond C. Major, 34, who has joined the company as manager of risk management. In this newly created position, Mr. Major is responsible for coordinating the efforts of the risk management department's staff. Previously, he was assistant vp of Johnson & Higgins in Wilmington. He received an associate's degree in marketing from Nassau Community College in 1972.

Robert M. Colasanto has resigned his position as director of employee benefits for Pacific Southwest Airlines in San Diego to become vp of Community Care Network, a San Diego preferred provider health care management system for San Diego County. In this new position, he will have overall management responsibilities for the company. Mr. Colasanto received a bachelor's degree in liberal arts from Rhode Island College in 1971, a master's degree in liberal arts from Brown University in Providence, R.I. in 1972 and a law degree from the University of Connecticut in 1976.

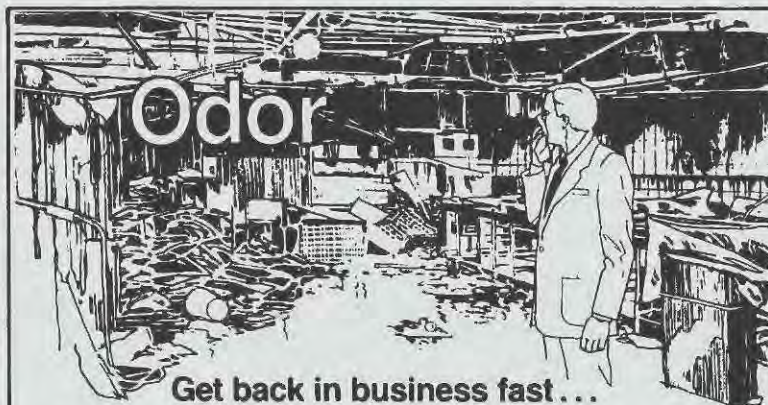
Mark Ferraro, 28, is the new risk manager for the city of Dallas. In this position, he is responsible for managing all city insurance and loss control programs. He reports to Jan Hart, director of budget research. Mr. Ferraro replaces Nancy Reppert, who is now risk manager for Pinellas County, Fla. Previously, Mr. Ferraro was risk manager for San Antonio, Texas. He received a bachelor of science degree in accounting from St. John Fisher College in Rochester, N.Y. in 1978, and a master's degree in business administration from the University of Dallas in 1980.

Scott Wyatt, 38, has replaced Mr. Ferraro as risk manager of San Antonio. Mr. Wyatt is responsible for the coordination of all insurance programs for the city, including liability, workers compensation and employee benefits. He also is

responsible for the city's safety programs. He reports to Carl White, financial director. Previously, Mr. Wyatt was claims manager for Tesoro Petroleum Corp. in San Antonio. He received a bachelor's degree in business from Texas State University in 1969 and has earned the Associate in Risk Management designation.

Sharon K. Wilson, 27, has been named risk management officer of Old Kent Bank & Trust Co. in Grand Rapids, Mich. In this newly created position, Ms. Wilson is responsible for the coordination and purchase of all insurance programs for Old Kent Financial Corp., a bank holding company in Grand Rapids and its affiliates. She reports to R. Jay Palmer, vp of risk management. Previously, Ms. Wilson was insurance administrator for Pacesetter Financial Corp. in Grand Rapids, a bank holding company that merged with Old Kent Financial Corp. in 1983. She earned a bachelor of science degree in management from Ferris State College in Big Rapids, Mich., in 1979 and is studying for the Chartered Property & Casualty Underwriter designation.

We'd like to report on staff changes in risk management, safety or benefits departments. Contact Diane Kastiel, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.



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# Royal to reorganize property/casualty lines

Royal Insurance Co. is planning to reorganize its U.S. property/casualty operations into two distinct groups.

A general insurance operation will focus on small- to medium-sized commercial line accounts and personal lines.

A special insurance group will concentrate on larger commercial and specialty lines, national and multinational business and excess and surplus lines.

The reorganization is expected to be "well in place" by mid-1986, when Royal will move its headquarters to Charlotte, N.C., from New York, according to the company.

"The reorganization will enable Royal to capitalize on the substantial differences between general and special insurance and contribute significantly to making us a truly market-driven organization," said George W. Ansbro, Royal's chairman and chief executive officer.

## markets

### Maclean, Oddy unit

Maclean, Oddy & Associates Inc., a Dallas brokerage, has formed Maclean, Oddy-International to produce and market insurance and reinsurance for international accounts.

According to Maclean, Oddy, the new division will accept submissions from domestic and foreign insurance brokers and agents and will provide markets for property, liability, marine and aviation insurance.

The division will accept business from U.S. brokers for clients that have expanded outside the country and need coverage in foreign countries; from overseas brokers for multinational clients that have expanded into the United States and need U.S. coverage; overseas brokers that need additional capacity

from U.S. markets; and foreign insurance companies and pools that require reinsurance protection of foreign risks.

The division is located at 2121 San Jacinto, Suite 1818, LB7, Dallas, Texas 75201; 214-969-0090.

### A&A acquisition

Alexander & Alexander of New York Inc. has acquired American Coverage Corp. of Great Neck, N.Y., in exchange for about \$7.5 million in stock.

American Coverage, which was ranked by *Business Insurance* as the nation's 73rd largest broker, with 1983 revenues of about \$3.3 million, specializes in real estate and manufacturing risks.

### MGA appointed

Black/White & Associates, a San Francisco-based excess/surplus lines brokerage, has been given authority to act as a managing general agent for Great Southwest Fire Insurance Co.

Great Southwest is a Scottsdale, Ariz.-based surplus lines insurer. In fiscal 1984, the company wrote \$94 million in gross premiums.

### St. Paul units acquired

AMEV Holdings Inc. in New York has acquired the life insurance and mutual fund subsidiaries of The St. Paul Cos. Inc. for \$135 million, according to AMEV.

The life insurers obtained by AMEV are Western Life Insurance Co. and St. Paul Life Insurance Co., both of Woodbury, Minn. They were purchased by AMEV's Time Insurance Co. of Milwaukee unit.

The mutual fund operations purchased directly by AMEV are St. Paul Advisers and its subsidiaries.

### Division name change

The Hartford Steam Boiler Inspection & Insurance Co. has changed the name of its Special Inspection Services Division to the Engineering Services Division.

The company said the new name reflects its efforts to continue expansion of Hartford Steam Boiler's inspection, testing, design and

training services.

### Purchase finalized

Lincoln National Corp., the Fort Wayne, Ind.-based insurance holding company, has completed its purchase of National Reinsurance Corp., a Continental Corp. subsidiary, for about \$73 million.

Lincoln National and Continental had reached a preliminary agreement for the purchase of the reinsurer in September (*BI*, Nov. 5, 1984).

National Reinsurance, headquartered in Stamford, Conn., is a direct writer of property/casualty reinsurance. The company reported \$101 million in written premiums in 1983.

### Work comp captive

A new captive insurance company, River City Reinsurance (Cayman) Ltd., has been formed to provide workers compensation coverage for 21 California employers.

The new captive, a subsidiary of River City Holdings (Cayman) Ltd., will be capitalized at \$180,000. Annual premium volume is expected to be around \$1.5 million.

Captive & Self Insurance Services Inc., which helped form the joint-venture captive, will manage the new company through its Cayman-based affiliate, CSI International Underwriting (Cayman) Ltd.

The California employers represent various industries throughout the state, including medical, high-technology, industrial and financial services firms.

### Metro Health acquired

HealthAmerica Corp., an independent operator of health maintenance organizations, has agreed to acquire 40% of Metro Health Inc. of Indianapolis.

The remaining 60% of the HMO's stock will be distributed to employees and physicians associated with Metro Health, according to HealthAmerica.

Metro Health operates six medical centers in the Indianapolis area. The program has 72,000 enrollees.

HealthAmerica operates HMOs in 26 markets in 16 states and plans to open two HMOs in early 1985.

### New Allstate offices

Allstate Life Insurance Co. has opened sales offices in Baltimore and Cincinnati to offer group life, health, long-term disability and dental coverages through brokers in the two cities.

Mark J. Perzinski has been named manager of the Baltimore office, and Paul Teismann will manage the Cincinnati branch.

Addresses for the Allstate offices are: The Earls Building, Second Floor, 311 Pike St., Cincinnati, Ohio 45201; 513-977-3479; and The Baltimore Federal Building, Suite 1420, 300 E. Lombard St., Baltimore, Md. 21202; 301-659-0400.

### New offices

A.S. Hansen Inc. has moved its corporate offices to The Lake-Cook Office Centre, 1417 Lake-Cook Road, Deerfield, Ill. 60015; 312-948-7400.

The FPE Group has moved its corporate office to 3687 Mount Diablo Blvd., Lafayette, Calif. 94549; 415-283-8860.

The H.T. Bailey Insurance Agency is moving its Boston offices to 22 Mill St., Arlington, Mass. 02174; 617-641-4400.

Noble Lowndes International Inc. is opening a new office in San Francisco. The address is 649 Mission St. at New Montgomery, San

Francisco, Calif. 94105; 415-777-0550.

U.S. Administrators Inc., a third-party employee benefit administrator, will open a regional office in the Pittsburgh area on Feb. 1. The office will be located at 333 Rouser Road,, Coraopolis, Pa. 15108; 412-269-1994.

Rollins Burdick Hunter Agency of Texas Inc. has relocated its office to Interfirst Financial Center N.W., 6243 IH 10 West, Suite 550, San Antonio, Texas 78201; 512-736-4561.

The Houston branch of Geo. F. Brown & Sons Inc. has moved to new offices at 10777 Westheimer, Suite 916, Houston, Texas 77042; 713-781-5767.

Delta International Reinsurance Co. Ltd. has opened an underwriting office at 14 Fenchurch Ave., London EC3M 5BS, England.

Carson, Luebbenhusen & Burk Inc., a Fort Worth, Texas-based insurance brokerage specializing in energy products, has opened an office at 1360 Post Oak Blvd., Suite 1620, Houston, Texas 77056; 713-993-9363.

National Aviation Underwriters Inc. has relocated to 3301 Rider Trail South, Earth City, Mo. 63045. The firm's mailing address is P.O. Box 10099, Lambert International Airport, St. Louis, Mo. 63145; 314-291-1150.

Crum & Forster Underwriters Co. of Ohio has begun writing business in that state. The firm is located at 144 Merchant St., Cincinnati, Ohio 45246; 513-772-3200.

Mutual of America, a life insurance company headquartered in New York, has opened a Rochester, N.Y., office. The regional office is located at 1 Marine Midland Plaza, Suite 1603, Rochester, N.Y. 14604; 716-325-4420.

M.F. Bank & Co. Inc., a salvaging and appraisal firm headquartered in Minneapolis, has added three offices, bringing its total to 23. Branches have been added at 5717 W. 85th St., Indianapolis, Ind. 46268, 317-875-9077; 11100 Roxboro Dr., Oklahoma City, Okla. 73132, 405-728-3856; and 830 Busch Court, Columbus, Ohio 43229; 614-885-3337.

### Mergers/acquisitions

Burns & Wilcox Ltd., a national managing general agency, has purchased American General Agency in Utah. American General will become the western regional office and will be renamed Burns & Wilcox Ltd.-West. The office is located at 1130 W. Center St., North Salt Lake, Utah 84054; 801-298-7555.

Amalgamated Programs Corp. and A. Matarasso & Co. Inc., two New York insurance brokers, are merging to form APCO-Matarasso. The new company will operate offices at 6 Corporate Park Drive, White Plains, N.Y. 10604; 212-931-8900; and 161 Williams St., New York, N.Y., 10038; 212-964-3044.

John Burnham & Co.'s commercial insurance division in San Diego has acquired Santa Ana, Calif.-based Amberwood Insurance Brokers. Amberwood will be merged into Burnham's office in Newport Beach, Calif.

Berwanger Overmyer Associates in Columbus, Ohio, has acquired Hoffhines Ross Insurance Agency of Columbus.

Braun-Hunsaker & Associates Inc., an independent agency in St. Louis, has merged with Charles L. Crane Agency Co. of St. Louis.

Frank B. Hall & Co. Inc. has acquired Bateman, Nugent, Chase, Field & Reilly Inc., an insurance agency in Providence, R.I., and its subsidiary, James J. Reilly Agency Inc. of East Providence. ■

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of Tampa, Florida

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**MARINE MIDLAND BANK**

## Lloyd's is mum on charges against ex-Howden officials

By STACY SHAPIRO

LONDON—Lloyd's of London will not comment on reports in the British press that three former officials of Alexander Howden Group P.L.C. have been charged with misconduct by a Lloyd's disciplinary committee.

According to the reports, the committee had charged former Howden Chairman Kenneth Grob, former underwriter Ian Posgate and former director Ronald Comery with misconduct.

Howden and parent company Alexander & Alexander Services Inc. have accused the three men, along with former Howden Treasurer Alan Page and former Director Jack Carpenter, with diverting millions of dollars in premiums to reinsurance companies they secretly controlled.

Lloyd's Chief Executive Ian Hay Davison said last week that once charges have been made by Lloyd's, the accused have the right to appeal before the Council of Lloyd's decides on a final verdict and sentence.

Mr. Davison said the council will reach a final verdict in the Howden case over "the next months."

In a related matter, John Wallrock, former chairman of Lloyd's of London broker Minet Holdings P.L.C., wants a public hearing when he appears before a Lloyd's disciplinary committee later this year, Lloyd's Chairman Peter Miller says.

Mr. Wallrock's hearing is expected to be held in April or May, Mr. Miller added.

Mr. Wallrock resigned as chairman of Minet in 1982 after he admitted to benefiting from reinsurance purchased for Lloyd's syndicates managed by a Minet affiliate.

### Tax on pension funds?

Observers are speculating that the British government will propose to tax the investment income earned by pension funds when it announces its new budget in March.

However, pension fund officials and others are working hard to convince the government that such a tax would not be a good idea.

Workers will wind up with smaller pensions if Chancellor of the Exchequer Nigel Lawson imposes the tax, explained John Craddock, marketing director of Legal & General Group P.L.C., the largest insurer of pension funds in Europe.

If a 25% tax were imposed on the investment income and capital gains of pension fund contributions, employers' pension costs would rise, Mr. Craddock said.

"Such an increase would seriously damage firms' competitiveness, both at home and abroad, to such an extent that they may be forced to cut back on pension scheme benefits," he said.

### Lloyd's accountants

Lloyd's of London has begun to examine the accountants who audit Lloyd's syndicates to make sure they are suitable for the jobs.

Those auditors who are found suitable will be listed by Lloyd's as approved auditors for Lloyd's syndicates by Dec. 31. All Lloyd's syndicates will have to be audited by these Lloyd's approved accountants beginning in 1986.

These are the main provisions of the Lloyd's Syndicate Audit Arrangements Bylaw that recently was approved by the Lloyd's Council.

The bylaw provides for a list of recognized auditors to be main-

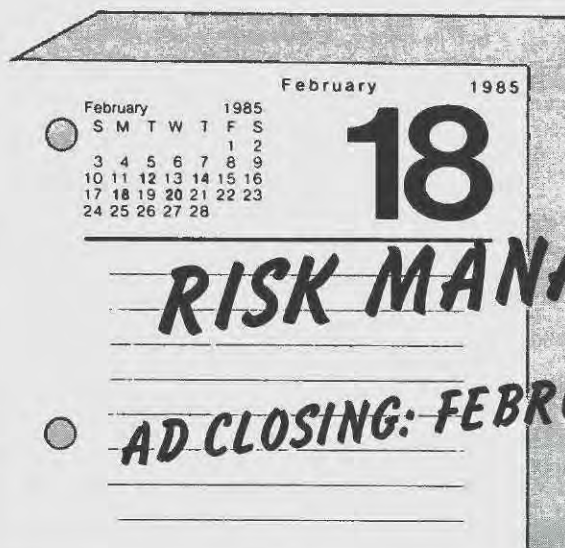
### *london line*

tained by the council. The auditors may not be the same accountants who are used by the underwriting agencies that manage the syndicates. But, the auditors can be appointed by the underwriting agency.

The council will have the power to remove the firms from the list. However, a firm can appeal its removal, and a firm can refuse to be included on the list.

The entire process of reviewing will not be completed until the end of the year, said Lloyd's Chief Executive Ian Hay Davison, who is chairing the Syndicate Auditor Registration Committee. ■

## COMING SOON



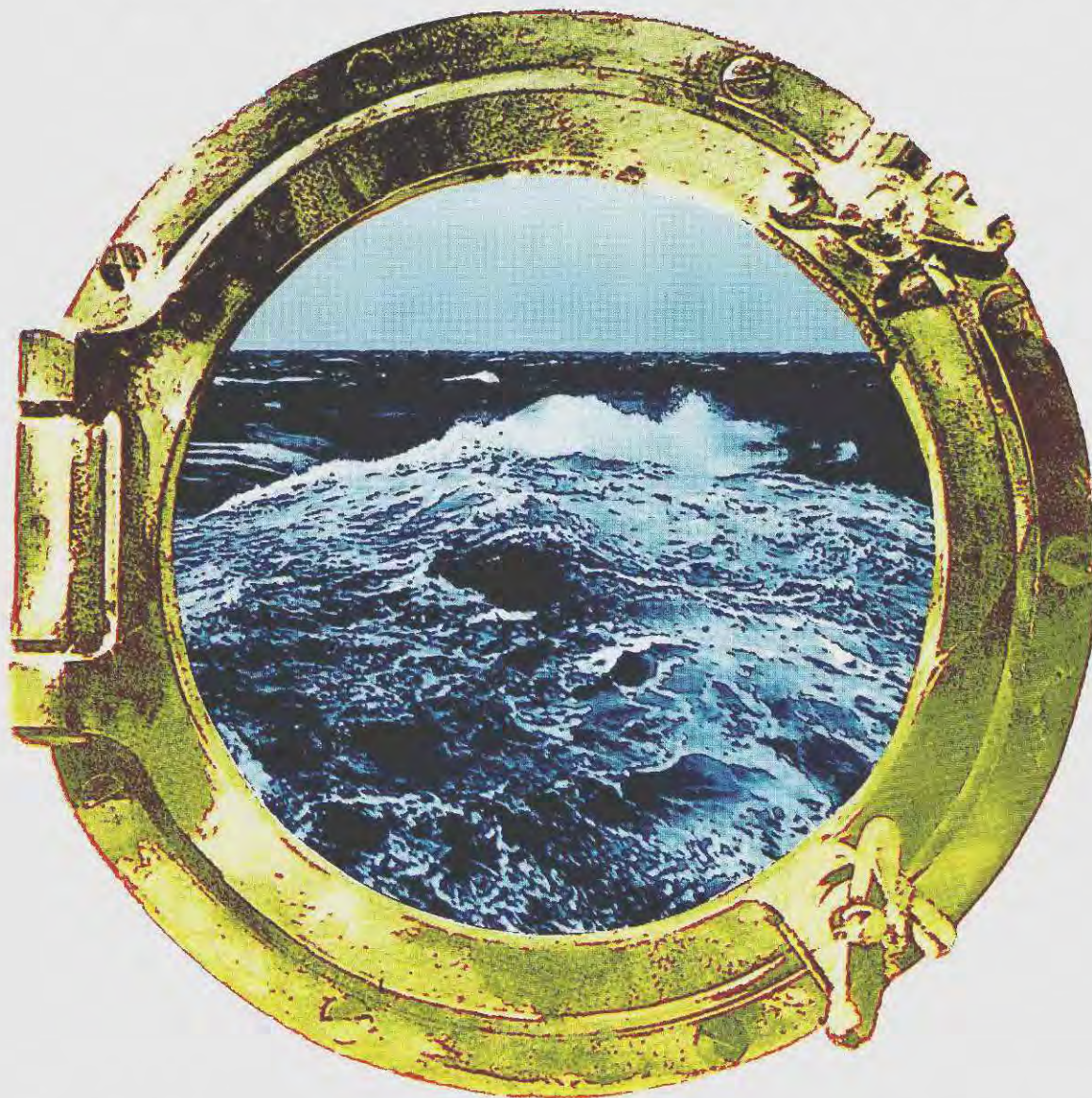
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# Way resigns as Travelers Corp. president

**Alva O. Way** has resigned as president of Travelers Corp. in Hartford, Conn., citing personal reasons.



Mr. Way

**Edward H. Budd**, who is currently chairman and chief executive officer, will also assume the post of president.

Mr. Way will remain a member of the board of directors and will become a consultant to the company. He joined Travelers as president in 1983. Before joining Travelers, he was president of American Express Co. and chairman and chief executive officer of American Express International Banking Corp.

Mr. Budd, 51, joined Travelers in 1955.

## Other insurer changes:

**G. Wayne Crawford** appointed to the newly created position of executive vp at Industrial Risk Insurers, an association of 43 leading insurers based in Hartford, Conn. Mr. Crawford had been senior vp. **James J. Banyas** named vp of the Westmoreland Casualty Co., a Latrobe, Pa.,-based property/casualty insurer. He had been vp and general manager of the Home Insurance Co.'s Pittsburgh Profit Center.

**W. John Becker** named vp of claims at the Excelsior Insurance Co. in Syracuse, N.Y. He had been a field claim manager in the Albany, N.Y., area for a major insurer.

**William J. Collins** elected president and chief executive officer of the Fremont Indemnity Co. Mr. Collins had been executive vp and chief operating officer of the Los Angeles-based workers compensation specialty company, which is a subsidiary of the Fremont Insurance Group.

As part of a corporate realignment at Blue Cross & Blue Shield of Connecticut in North Haven, **Anthony J. Martin** promoted to senior vp for health delivery systems; **Harry J. Torello** promoted to senior vp for operations; **John R. Anderson** promoted to vp for government programs; **Anne M. Leonore Fiskio** promoted to vp for benefit payments; and **Carole Organek** promoted to vp for provider affairs.

**Bertram W. Sealy Jr.** elected president and general manager of Fidelity Insurance Co. of Canada, a subsidiary of USF&G Corp. Mr. Sealy had been vp of the Home Office Field Operations Department.

## Other suppliers

The employee benefit consulting firm of Kwasha Lipton has elected two new partners and three new principals. **Ira G. Kastrinsky** and **Peter D. Mundy** were elected partners at Kwasha Lipton, the Fort Lee, N.J., consultant, while **Sheila N. Berkman**, **Sarah H. Githens** and **Barry S. Levine** have been named new principals. Mr. Kastrinsky joined Kwasha Lipton in 1973 and is a consultant on both defined benefit and defined contribution plans. Mr. Mundy joined the firm in 1984 and is responsible for the development and refinement of the firm's defined contribution plan record-keeping system. Ms. Berkman joined Kwasha Lipton in 1978 and is a consultant on defined contribution plans. Ms. Githens joined the firm in 1975 and is a consultant on defined benefit plans and is responsible for the firm's actuarial valuation computer system. Mr. Levine joined the firm in 1977 and is a member of the legal department.

## comings & goings: industry

**Charles M. Mulle** and **Cameron J. Bruce Jr.** joined Rollins Wrightson Co., a financial institution insurance consultant, as vps. Mr. Mulle had been director of insurance for Merrill Lynch Corp. and Mr. Bruce had been risk manager of Lehman Brothers Kuhn Loeb Inc. Both will be based in the New York office of the Rollins Burdick Hunter Co. subsidiary.

Also, **Norman C. Storbakken** named president and chief operating officer of MII Services, a unit of Blue Cross & Blue Shield of Minnesota that provides third-party administration for self-insured companies.

At Yaffe & Offutt Associates Inc.,

**Joyce H. Perez** joined as a consultant and **Christina G. Krach** joined as pension plan administrator. Before joining the Baltimore-based employee benefit and consulting firm, Ms. Perez was an account executive for EMC Colorado, a health maintenance organization. Ms. Krach was a compensation and benefits administrator with A.S. Abell Co.

**Robert L. Bein** named manager of Edward H. Friend & Co., a Washington-based pension and actuarial firm that is a unit of Johnson & Higgins. Mr. Bein had been a vp in the employee benefits department of Johnson & Higgins. He has also been elected a senior vp of

Johnson & Higgins of Washington, D.C., which oversees Friend.

**Michael L. Wheat** promoted to manager of the Pittsburgh office of Buck Consultants Inc., an employee benefit consulting firm based in New York.

**James A. Rowan Jr.** named chief operating officer at General Health Inc., a Washington-based health risk management consultant. He had been president of consultant Kedears Hill Inc.

**John J. Dubreuil** named president of Claims Management Systems Inc. in Sarasota, Fla., which provides specialized workers compensation claims administration services. Mr. Dubreuil also is vp of Waters Insurance Management Corp., administrator of the Florida Construction, Commerce & Industry Self-Insurance Fund.

At International Medical Exchange in Los Angeles, **Joseph A. Syiek** named senior vp of development services, **Robert R. Whiton** named senior vp of operations, and **Ronald E. McCray** named vp of systems. IMX is an independent management services company for buyers payers and providers of health care. Mr. Syiek had been with Arthur Young & Co., Mr. Whiton had been with Advanced Health Systems and Control Data Corp., and Mr. McCray had been with Humana Corp.

**Gary D. Peterson** named president and **John B. Fraser** named vp of finance and treasurer of the newly formed HMO Nebraska Inc., a health maintenance organization subsidiary of Blue Cross & Blue Shield of Nebraska. Mr. Peterson

*Continued on facing page*



Continued from facing page and Mr. Fraser both held positions with BC/BS of Nebraska.

**Richard A. Lewis** named president of Thomas L. Jacobs & Associates Inc., disability administration and health care cost management consultants in Chicago. He had been executive vp. Also, **Richard H. Wille** named executive vp in charge of technical claim services, and **Barbara L. Baldwin, Paula M. Lundell** and **Mary Lou Williamson** named principals.

**Carole L. Kennedy** named senior vp of U.S. Administrators Inc. in Los Angeles. Ms. Kennedy, who will also be chief operations officer of U.S. Administrators, had been vp of Blue Shield of Pennsylvania.

**Sharyn L. Colegrove** joined Advanced Risk Management Techniques in Laguna Hills, Calif., as affiliate consultant. She had been risk manager for South Bay Hospital District in Redondo Beach, Calif.

**R. Stephen Taylor** appointed vp

of RS Administrative Services Group, the claims administration division of Reed Stenhouse Associates Inc., employee benefits consultants and actuaries. Mr. Taylor will be based in Houston. He had been manager of employee benefits of the trust division at First City National Bank of Houston.

**David R. Godofsky** joined Booke & Co., a consulting firm based in Winston-Salem, N.C., as vp and associate actuary of the Birmingham, Ala., office. He had been associated with an actuarial consulting firm in St. Louis.

### Reinsurance

**Paul Walther** joined Hamburg International Reinsurance Co. as senior vp in charge of property and casualty treaty reinsurance. He had been with Commercial Union Reinsurance Co.

**Jeffrey Jackson** promoted to vp in the Chicago office of General Reassurance Corp., the life reinsur-

ance subsidiary of the General Re Group.

**Robert J. Striffler** and **Robert K. Peglar** promoted to senior vps at the John F. Sullivan Co., based in Seattle. Both Mr. Striffler and Mr. Peglar joined the company in 1981, and both are in the New York office.

**D. Jay Carbine**, chairman and chief executive officer of Richard Whiley Inc., also named president of the New York-based reinsurance intermediary. He replaces **Donald Law**, who resigned to return to his native Australia.

### Agents/brokers

At Johnson & Higgins Willis Faber Ltd. in Toronto, Canada, **Ian Alexander** named senior vp and manager of the newly formed Midwest Region, which includes offices in Manitoba, Saskatchewan and Alberta; **Edmund A. Turcotte** named senior vp and manager-Calgary; **Claude St. Pierre** named se-

nior vp and manager of the newly formed Quebec region, which includes Montreal, Quebec City, Sept-Iles and Baie Comeau; and **Ian D. Robinson** named senior vp and manager of the Atlantic Region. The region includes offices in Newfoundland and Nova Scotia.

Also at Johnson & Higgins Willis Faber Ltd., **Guy A. Jobin** named senior vp of employee benefits-national, **Philip G. Kane** named senior vp of property/casualty-national and **Brian W. Jones** named vp of business development-national. Mr. Jobin, who had been vp and manager of employee benefits-Montreal, will be based in Montreal. Mr. Kane, who had been senior vp of national marketing, will be based in Toronto. And, Mr. Jones, who had been vp of the international division, also will be based in Toronto.

**Jayne D. Maas** named vp and director of taxes at Alexander & Alexander Services Inc. She joined A&A in 1976.

**James R. Craig** named president of Reed Stenhouse Inc. of Texas, located in Houston. Before joining Reed Stenhouse, Mr. Craig had been with Liberty Mutual Insurance Co.

**Richard W. Wright** named vp of the captive development and planning division of Fred S. James & Co. Inc. in New York. Mr. Wright had been head of the risk management department of Emmett & Chandler in New York. Also at Fred S. James, **E. Timothy Kenneally** named executive vp and managing director of Fred S. James & Co. Inc.'s Financial Products Group. He had been a vp of CIGNA. And, **Leo Jacobsen** named manager of the Los Angeles office of Fred S. James. Mr. Jacobsen had been executive vp and operating officer of the Los Angeles office.

**John P. Olsen** named executive vp of Fred S. James & Co. of New York Inc. in New York City. He had been senior vp.

## Tiger-bite victim gets settlement from park insurers

LAGUNA HILLS, Calif.—The annuity that will pay as much as \$20 million to a child mauled by a tiger in 1982 at Lion Country Safari here is being purchased from Connecticut General Life Insurance Co., a CIGNA Corp. unit, a plaintiffs' attorney says.

The annuity was paid for by Alliance Insurance Co. in McPherson, Kan., which was the park's primary liability insurer, and Protective National Insurance Co. in Omaha, Neb., which was the park's excess insurer, says C. Marian Graham of Herbert Hafif Law Office in Claremont, Calif.

Ringler Associates Inc., structured settlement brokers in Newport Beach, Calif., placed the annuity. The transaction was arranged by B.R. Martin Co., a Glendale, Calif., litigation management firm hired by Alliance to settle the case, she said.

Neither the park nor its broker, Emmett & Chandler of Los Angeles, would discuss its insurance program.

Norm Amick at NATESCO Underwriters Inc., Dallas underwriting manager for Alliance, says Alliance wrote liability limits of \$500,000 for the park at the time of the accident. That coverage expired in December 1982; Alliance no longer underwrites the risk, he said.

The boy, Anthony Stopani, was mauled in October 1982 by a 500-pound tiger that had escaped into a crowd of visitors. The tiger's teeth punctured the child's brain and his left leg.

The boy underwent extensive surgery, but he still suffers mild paralysis on the left side of his body.

Doctors are still not certain of the boy's mental capabilities, but they say he has a high risk of contracting epilepsy later in life.

According to the settlement, Anthony will receive \$375,000 now and \$1,000 monthly until he reaches age 21. Monthly payments will then increase to \$5,000 for life, at a minimum 4% interest compounded annually. By age 61, he will receive more than \$23,000 monthly, Ms. Graham says.

Anthony will also receive \$15,000 annually for four consecutive years when he turns 18.

At age 25, he will begin to receive a series of lump sum payments, starting with \$100,000 and increasing in \$50,000 increments every five years for life. So at age 65, he will receive \$500,000.

His parents, Carlos and Naomi Stopani, will receive a lump sum of \$200,000 now, and his two brothers, who also saw the accident, will each receive \$10,000 annually for four years when they reach age 18.

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# BUSINESS INTERRUPTION

## Analysis helps determine how much coverage is enough

By Arthur E. Parry

**F**OR YEARS, business interruption insurance has been written to cover "the reduction in gross earnings... (which results from) the interruption of business." From the standpoint of the insured, this requires answering the following question: What would the gross earnings be if no loss occurred?

Books, articles, worksheets and countless explanations have covered business interruption, but invariably the question is asked (and not answered): How much business interruption insurance do I need?

The answer is difficult to find because:

- A business interruption loss is sustained over time. It is not similar to a property loss, or even to a casualty accident, although "payouts" for casualty may be over time.

- The loss begins at some time in the future (because it is sustained over time) so different losses of the same duration (and presumably of the same magnitude) are often of different size.

- Calculations of the amount that the business would have earned is difficult at best and subject to both historical comparison and other factors that are "future" in time.

This brief analysis, based on an actual case, may help establish a method for the manufacturer or retailer who wants a tool or a method that will guide him or her in developing an adequate, but not excessive, amount of insurance.

For our sample manufacturer, the provisions in the next two paragraphs were put in place:

Building and contents coverage were written on a blanket basis on an agreed amount/replacement basis, including a manufacturer's selling price clause. The amount of insurance for the property was properly supported, and with these additional extensions eliminated any concerns about adequacy of such coverage.

Business interruption and extra expense coverage were also written on a blanket basis with an agreed-amount clause and with ordinary payroll



Arthur E. Parry is manager of risk management services for the Wyatt Co. in Dallas.



included. In addition, no limiting percentages were applied to the extra expense, although an extra expense worksheet had been completed to verify the reasonableness of the relationship between extra expense and business interruption. Further, interim worksheets were prepared to assist in identifying the business interruption exposure.

Yet, the question remained for management: Do we have enough business interruption insurance?

To answer the question, a step-by-step analysis of business interruption insurance needs was performed.

To begin, the analysis recognizes that business interruption loss occurs over time, which means, first, that the date the loss begins is not known, and second, that the length of time of the loss as well as the variation in restoration will depend on the date of the loss.

As a result, the actual amount of insurance needed will be different, depending on the date the loss begins. Therefore, several steps are required to arrive at an adequate amount of insurance. These steps may be identified as follows:

• **Step 1: Forecasting of sales in weekly or monthly periods.**

The business interruption worksheet uses "annual" figures, but the firm usually has weekly or monthly figures available. Monthly historical figures need to be graphed and future sales included to identify the seasonality of sales, both historically and prospectively. This will convert sales values for the future periods to a monthly basis. The sales graph is shown in Exhibit 1.

• **Step 2: Forecasting expense factors for weekly or monthly periods, as Step 1.**

Just as sales values require monthly adjustment,

appropriate handling is needed for the costs and expenses that don't continue. (A review of the particular client's history suggests that, on average, a 45% reduction for costs and expenses would be appropriate to reflect the reduction in sales values.) Monthly sales value with reductions as well as four levels of gross earnings percentages—100%, 75%, 50% and 25%—are shown for the 18-month period beginning October 1984 in Exhibit 2.

• **Step 3. Estimation of the time involved in a shutdown of business.**

Considerable analysis is needed to develop an acceptable maximum time period for a total loss. This includes a consideration of available secondary manufacturing space, set-up time for replacement operations, availability of new equipment, subcontracting of certain processes, etc. A four-month time period was ultimately selected as the time that might be involved in a total loss.

• **Step 4. Estimation of the slowest recovery for a loss involving a gradual restoration of business.**

Further examination of various scenarios under a loss situation suggested that a maximum graduated shutdown would be two months at 100% and two months each at a 75%, 50% and 25% shutdown level. The amount of gross revenues lost under each shutdown level are included in Exhibit 2.

• **Step 5. Conversion of values above and forecasts above into chart form.**

Exhibit 3 displays both the total shutdown and graduated shutdown values for ease of use.

Based on the above, it is then possible to provide meaningful values for any loss beginning in any of the next 12 months. The approach should be continued at regular intervals to assure adequate amounts of insurance, although updating would be easier to maintain than development of the original approach.

Developing realistic monthly business interruption values requires the following: historical and projected monthly sales values (of production); seasonal analysis of the above; reasonable gross earning ratios; an evaluation of the length of time involved in a total loss as well as recovery estimates (gradual restoration); and appropriate handling of related factors (coinsurance, agreed amount, ordinary payroll, interim statements, etc.).

The approach outlined here is probably used, at least in part, by most risk managers in determining a needed amount of insurance. Hopefully, the charts and steps will prove beneficial to others as well.

It should be remembered that application of this approach does not change the actual loss adjustment method. What it does is provide the basis for a reasonable up-front determination of the amount of insurance required as well as an approach to assure an ongoing adequate limit.

	Month	Net sales value	Deductions*	Gross earnings			
				100%	75%	50%	25%
1984	October	\$ 2,000,000	\$ 900,000	\$ 1,100,000	\$ 825,000	\$ 550,000	\$ 275,000
	November	2,000,000	900,000	1,100,000	825,000	550,000	275,000
	December	2,000,000	900,000	1,100,000	825,000	550,000	275,000
1985	January	2,200,000	990,000	1,210,000	907,500	605,000	302,500
	February	2,200,000	990,000	1,210,000	907,500	605,000	302,500
	March	2,200,000	990,000	1,210,000	907,500	605,000	302,500
	April	2,500,000	1,125,000	1,375,000	1,031,250	687,500	343,750
	May	2,500,000	1,125,000	1,375,000	1,031,250	687,500	343,750
	June	2,500,000	1,125,000	1,375,000	1,031,250	687,500	343,750
	July	2,800,000	1,260,000	1,540,000	1,155,000	720,000	385,000
	August	2,800,000	1,260,000	1,540,000	1,155,000	720,000	385,000
	September	2,800,000	1,260,000	1,540,000	1,155,000	720,000	385,000
	October	2,500,000	1,125,000	1,325,000	1,031,250	687,500	343,750
	November	2,500,000	1,125,000	1,325,000	1,031,250	687,500	343,750
	December	2,500,000	1,125,000	1,325,000	1,031,250	687,500	343,750
1986	January	2,800,000	1,260,000	1,540,000	1,155,000	720,000	385,000
	February	2,800,000	1,260,000	1,540,000	1,155,000	720,000	385,000
	March	2,800,000	1,260,000	1,540,000	1,155,000	720,000	385,000

\* Raw stock, supplies, merchandise sold, non-continuing services.

Year	If loss began first day of	4 month shutdown	Shutdown as follows:
			2 months 100%, 2 months each 75%, 50%, 25%
1984	October	\$4,510,000	\$5,830,000
	November	4,620,000	5,995,000
	December	4,730,000	6,228,750
1985	January	5,005,000	6,503,750
	February	5,170,000	6,660,000
	March	5,335,000	6,816,250
	April	5,665,000	7,063,250
	May	5,830,000	7,155,000
	June	5,995,000	7,328,500
	July	5,995,000	7,411,250
	August	5,830,000	7,320,000
	September	5,665,000	7,178,750

# Don't increase LTD costs just yet

## Research all options before making employee pay more

**Q:** *We've been advised by our broker that the insurer for our long-term disability plan is increasing our LTD rates by more than 50%. Our broker feels the rate increase is justified by our most recent 12-month claims experience. The LTD plan is almost wholly paid for by the participants, and I feel the increase in cost should be paid by them. How do you suggest we communicate this to employees?*

**A:** Employees are understandably more critical of benefit "cutbacks" than they are appreciative of benefit improvements. This is especially true when the cutbacks come in the form of increased payroll deductions and affect their take-home pay.

Therefore, unless you have made every effort to keep the costs of your LTD program at a minimum and have regularly communicated these efforts to employees, I suggest that you defer passing the increase along to participants until you have studied all of the options available to you.

Consider the following alternatives:

- Because of the long-term liabilities associated with LTD claims, insurance companies are generally more conservative in establishing reserves for this coverage than for other coverages.

This is especially true if your insurer is on the risk for those industries that have been hit hard by the recent recession, since tough economic times invariably generate more disability claims.

In fact, the size of the rate increase proposed by your insurer suggests to me that its overall book of LTD business may be unfavorable and that it is attempting to withdraw from the market or severely limit its liability.

Accordingly, you should consider asking your broker to obtain quotations from other insurers. Be sure that these other companies receive complete specifications for your LTD program, including current census data and detailed claims experience for your plan for at least the most recent and preceding two policy years, and advise your current insurer that you are requesting competitive quotations.

- Consider the adoption of a Voluntary Employee Beneficiary Assn., also called a 501(c)(9) trust, for your program. LTD benefits are especially suited to this type of funding vehicle because claims, although generally infrequent, are for a longer duration, and substantial reserves are required.

The major advantage of a VEBA is that the investment earnings on these reserves accumulate tax-free and you are not required to pay premium taxes.

However, you must understand the integration requirements imposed by the Deficit Reduction Act of 1984 on LTD plans funded through VEBAs.

*Would you like the advice of an experienced colleague on a risk management or benefit management problem? Two features in the Perspective section of Business Insurance can give you some answers.*

*Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefit management issues.*

*While Joseph Duva answers benefit management questions, Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco, answers risk management questions.*

*Mr. Duva's and Mr. Perry's columns appear alternately on the second Monday of each month.*

*Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.*

# Q?A!

## ask a benefit manager

Specifically, if your pension plan is more than 90% integrated with Social Security, then your LTD plan is not permitted to offset 100% of Social Security benefits, and it may be necessary to change your long-term disability plan or your pension plan to comply with these integration requirements.

If possible, you should enlist the support of your broker and their actuary in this study. Your broker will lose commissions if you change from an insured to a self-insured basis, since this type of program is self-insured either internally or through an administrative-services-only contract with an insurer, but the broker can at least be assured of the actuarial fees required for the periodic actuarial valuation of your LTD plan.

And, because the broker is already familiar with your plan, the transition from an insured to a self-insured basis should be easier.

- Explore with your broker and the insurance company the possibility of amending those plan provisions that may have been subject to abuse in the past. This will require a detailed analysis of the benefits paid and the types and durations of the disabilities incurred under your plan as compared with industry norms.

For example, perhaps your definition of total disability

is too liberal, or you could reasonably extend the waiting period to provide for a more complete offset of disability payments received from other sources.

You may also want to consider an effective rehabilitation program to encourage disabled employees to return to work. Given these types of changes to the plan, the insurer may be willing to accept a lesser increase.

- Negotiate with the insurance company to effect the rate increase in moderate steps over a longer term, such as three years instead of one year, contingent upon the plan's experience.

If your insurer has had a long-term relationship with your company or broker and is interested in keeping the business, this could be an acceptable alternative, and it will give you the opportunity to phase in the increase and to manage your communications to employees over the longer term.

Any one or a combination of the above alternatives can serve to minimize the increase in contributions required of your employees.

You should also review each claim submitted for the past policy year to determine if management is using the LTD plan to handle terminations of questionably disabled employees by approving or encouraging the approval of their claims for disability benefits. One or two of these claims, for highly compensated individuals, can significantly affect your experience. And, if this is the case, it may be unfair to pass along the rate increase to your employees.

Once you have identified the reasons for the rate increase and have made every effort to minimize it, you can plan your communications to employees. If you clearly communicate these reasons and your efforts, you should be able to gain employee acceptance.

Remember to tell it "like it is" and to be as straightforward about the bad news as you would have been about the good news of a benefit improvement. ■

## Unit value accounting has advantages, but use care in explaining it to employees

**Q:** *My company's savings plan has three funds: an equity fund, a bond fund and a company stock fund. I have been told that the value of an employee's account in each of these funds is determined by the unit value accounting method. Would you explain this method and why it is used?*

**A:** Unit value accounting is one of three methods used in the administration of savings or thrift plans. The other methods are share accounting (which can only be applied to stock funds) and cash accounting.

The unit value accounting method converts the cash contributions that are made by the employer and employee to the plan into units by dividing the cash amount of the contributions by the then-current unit value.

The current unit value, which for most plans is initially set at 1.0, is computed by dividing the market value of a fund at the end of any given period (e.g., monthly or quarterly) by the number of units allocated to that fund at the beginning of the period.

For example, if \$200 were initially contributed to a fund whose unit value was set at 1.0, it would purchase 200 units (\$200 divided by 1.0).

If the market value of the fund increased from \$200 to \$300 at the end of a given period, the unit value for the fund would then be computed by dividing the market value of \$300 by 200 units, for a unit value of 1.5.

Conversely, the cash value of an employee's account at the end of a given period is computed by multiplying the number of units in the employee's account by the current unit value.

The advantages of using the unit value accounting method are:

- Simplified administration because there is no need to allocate earnings or investment experience that are recognized by changes in the unit value.

- A savings in computer usage for "class year" vesting plans because it is a simplified account structure.

- A convenient and precise measure of investment performance over any given period of time.

Because of these advantages, the unit value is widely used to administer thrift or savings plans or, indeed, most investment plans.

A major disadvantage of this method, however, is that it is an artificial measure of value, subject to accounting adjustments for the timing of contributions and withdrawals, difficult to communicate to employees and often hard for them to understand.

This is especially true of company stock funds where employees can measure the change in the price of the company's stock on a daily basis.

For example, if the price of your company's stock were to increase in value by 10% in a given month, employees might expect the fund's unit value to also increase by 10% for the same period of time.

Except in the instances of plan terminations, however, stock funds generally are never fully invested, and if only 90% of your company's stock funds were invested in stock during that month and the balance left in cash, the unit value would have increased by only 9%.

One of the major reasons for the popularity of savings and thrift plans is the personal interest that employees have in their individual accounts.

Benefit administrators are well-advised to thoroughly understand the unit value method and the other financial and accounting aspects of these plans so that they can effectively and credibly answer the questions of their employees. ■



*Joseph W. Duva is director of employee benefits and compensation at SCM Corp. in New York. Mr. Duva's next Ask A Benefit Manager column will appear in March.*

# Tips for settling fire loss claim

## Knowing what to do can help claimant avoid getting burned

By Adolph A. Neidermeyer  
and Fred E. Wright Jr.

**SUCCESSFUL SETTLEMENT** of a fire loss claim requires awareness, coordination, documentation and negotiation. Each of these activities is discussed below from the point of view of a claimant tackling the administrative requirements of settling a fire loss.

Awareness of coverage begins when the firm's management chooses an insurance agent. Choosing a conscientious, reputable agent is crucial to assuring that the initial and continuing coverage is provided at a reasonable cost. Management should review references, recommendations of associates, industry suggestions and community reputations on an as-available basis before selecting an agent. Price shopping should be considered, but this should not be the sole criterion used to select an agent.

Management of the covered firm should be aware of the exact coverage purchased: i.e., whether it represents replacement cost, actual cash value or an agreed-upon amount. Premiums will vary with the selected coverage, but so will the possible settlement amounts in the event of a loss. Management may want to compare costs and benefits under the various coverages before finalizing a policy.

An overriding consideration in choice of coverage is the importance of the covered item to the firm and its cost: If the facility is critical and costly, the firm should consider replacement-cost coverage because immediate replacement would be required if a loss occurred.

Policy coverage is dependent on the operating environment of the firm and management's willingness to assume risk. Management chooses from myriad coverages: Usually, policies are purchased that cover the operating building and contents (including inventory) from all risks, the operating fleet for comprehensive coverage of damage sustained/caused and the workforce for injuries sustained on the job.

Management also may purchase business interruption insurance to cover lost revenue from any of the above risks (i.e., a fire may destroy your warehouse; six months later you are back in operation, but your operating income is continued through this type of insurance).

Management should periodically review the firm's coverage with the agent. The agent has a responsibility to review customer coverage, but the primary responsibility rests with the policyholder. A suggested timetable for review is at each premium payment, or more frequently, if significant changes occur in covered items.

This review of policy coverage should include a request by the policyholder for a complete policy, including any endorsements. Subsequent to the receipt of these items, the policyholder should review the materials to determine that the policy documents are complete and that the coverage described matches that which is outlined in the original purchase. The covered firm should retain a complete copy of the policy in a safe place for future reference.

Updating of coverage should be completed as required under the administrative provisions of the policy. The normal stipulation is that any change should be reported to the agent within 30 days to assume continuity of coverage.

Some insurance firms require the insured to maintain and report a monthly perpetual inventory. This report provides a basis for assessing the adequacy of existing coverage as well as a starting point for determining the magnitude of any loss.

The insured needs to be aware of what is required when a loss is experienced. After the obvious action of

summoning assistance to mitigate the loss, the insured should notify the agent immediately. The agent will then decide whether an adjuster will be required to settle the loss—this choice is predicated on the magnitude or the complexity of the loss.

A third step for the insured is to use all the reasonable means to save and preserve the property at and after the loss occurs. Therefore, safeguard but do not disturb the loss site.

These rules apply because the state fire inspector's office usually attempts to determine the cause of a fire, and the insurance company will want to salvage everything possible.

If your loss does require an adjuster, ask about the

**Awareness of coverage begins when the firm's management chooses an insurance agent. Choosing a conscientious and reputable agent is crucial to assuring that the initial and continuing coverage is provided at a reasonable cost.**

adjuster's experience with cases like yours. A great deal of time and frustration can be alleviated if the adjuster is familiar with your business.

In the area of coordination, the insured should request an immediate conference with the assigned adjuster to initiate the claims process. Be very direct when questioning the adjuster; ask for specific formats of claims presentation and time frames. Find out what types of documentation to submit with the claim and how much detail is needed. Ask about the site review of documentation; the adjuster may want to review existing records on site rather than have them duplicated to accompany the submission of the claim.

The adjuster may want pictures of lost items, a verified list of items disposed of at a dump site and/or a list of items remaining at the loss site. Remember, the adjuster has to satisfy his or her superiors that he or she has reviewed the loss and substantiated the amounts claimed by the insured.

The adjuster should be able to offer a tentative time frame for settlement of the claim. If the period appears to be lengthy and you require a large amount of working capital to counteract the effects of the loss on operations, you may want to pursue a partial settlement.

Now the claimant is ready to document and submit the fire loss claim. Be certain to format and document the claim as requested by the adjuster. All communications should be dated and documented in writing; verbal communications should be followed with a written memorandum to provide a paper trail for the claim.

The claimant may want to consider employing outside assistance to prepare the claim—this separation does lend an appearance of independence to the claim, especially if the claimant employs an accounting firm to formulate and substantiate the entire loss or significant elements of the loss. The assistance is usually available on an hourly basis and can minimize the internal time spent on preparing the claim. Some policies provide payment for this type of service.

The submitted claim is the prime negotiating instrument, so care should be taken to compile a complete, fully documented submission. The claimant should retain a complete, indexed copy of the claim as submitted. This will enable the insured to respond to any questions raised

by the adjuster during the course of the settlement. Submission of the claim should be by mail with return receipt requested, to substantiate that a timely claim was filed.

The claimant should remember that the claim is usually negotiated—be prepared to substantiate the numbers describing your loss. During negotiations, it is in the claimant's best interests to become knowledgeable about applicable state laws, because in certain states insurance companies must make requests for additional information within a specified period or the claimant does not have to respond to the request. It is, however, in the best interest of the insured to furnish all of the information requested. The claimant should maintain weekly contact with the assigned adjuster to encourage action and promptly respond to any questions.

In the event that the claim is not settled satisfactorily through the normal process, the insured should be prepared for litigation. The prior documentation of all correspondence with the adjuster arranged in chronological sequence can be used as evidence of any failure on the part of the insurer to act in good faith to settle the claim.

Several meetings may be necessary to settle the claim to the satisfaction of both parties. The claimant should be prepared to attend lengthy meetings and to negotiate items that cannot be fully documented. Litigation can be costly in both time and money, so the claimant should try to reach an acceptable settlement through negotiations before resorting to legal action.

An effective negotiation is one in which both parties are relatively satisfied at the close of settlement. Note that once a settlement is offered and accepted and a release form is signed, no further claim can be made against the insurer. The negotiation stage offers bargaining opportunities to well-informed claimants who are aware of their policy provisions, who document their covered holdings, maintain proper coverage, report losses promptly and document the entire process.

Management prepares for the unexpected by transferring some of its risk to others. Insurance coverage accomplishes the transfer of risk if it is approached properly. Management should choose a reputable agent and subsequently maintain an updated information system.

An informed insured and a conscientious agent can complement each other to provide coverage that is adequate to cover any experienced loss if the documentation is available. The value of a complete information system is impressed upon those who lack the same and who have encountered a loss.

Management should review that adequacy of the insurance coverage periodically with the agent. This review assures the management of the firm that coinsurance requirements have been met, and that adequate dollar coverage is in place. If the firm subsequently experiences a loss, a properly functioning information system will possess the data for the claim submission.

Upon the occurrence of a loss, the adjuster should be notified immediately. All the activity is then directed toward coordinating with the agent/adjuster, documenting the detail of the claim and finally negotiating final settlement of the loss.

Anticipation of the unexpected puts management of the firm in a position to deal with these situations in an acceptable fashion. ■



Fred E. Wright Jr. (left) and Adolph A. Neidermeyer, Ph.D., are professors in the college of business and economics at West Virginia University in Morgantown.



The Perspective section, which is a forum for readers' opinions, is compiled and edited by Copy Editor Alison Kittrell. She can be reached at 312-649-5262.

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# Employer wants to refund 'unused' health contributions

Continued from page 3

Mr. Aycock disagrees with these criticisms. "I don't think that's true," he said. "I don't think it would cause people to let their children go around with broken arms and legs because they wanted to get the refund."

Louis Delsol, superintendent of schools in Mendocino County, Calif., agrees with Mr. Aycock.

The refund system used by the Mendocino County Office of Education sets aside \$500 for each employee. A dollar is subtracted for each dollar in claims filed by the employee each year, so an employee who files less than \$500 in claims is rewarded by the district (BI, Dec. 7, 1981).

"I don't think the argument (that refunds discourage people from getting necessary care) is valid because that would mean any plan where an employee has to dig into his own pocket would be a deterrent (to necessary care)," Mr. Delsol said.

But, the Mendocino plan has one feature that Mr. Delsol believes significantly deters employees from neglecting their health in exchange for cash: Refunds are "saved up" each year and only paid when an employee terminates his or her employment, he notes.

"The money isn't that immediate in the plan," he explained. "They know it's there and they like to think about it, but it doesn't keep people from seeking health care because it is so far removed."

Still, the program seems to have had an effect on health care costs: The county has kept health cost increases to an average of 7% for the six years the plan has been in effect, Mr. Delsol said.

Some consultants maintain that refund-type plans, like the gas company's proposal, won't save money because they don't eliminate the big-ticket items, like hospital stays.

"Maybe 80% of employees will stay healthy and get their contributions back, notes Stephen Carlson, principal at William M. Mercer-Meidinger Inc. in Chicago. "But the other 20% are going to get sick and they'll probably be very sick, to the extent that their expenses exceed what they put into the plan. Then the employer has to make up the difference."

According to Mr. Carlson, deductibles and co-payments are better ways to give employees a financial stake in what they spend on health care.

"The advantage of going the co-pay or deductible route is that the employer isn't subjected to those fluctuations," Mr. Carlson explained. "That's why it's important not to just have deductibles, but co-payments as well, so that the employee continues to have a financial interest in the plan on an ongoing basis."

However, this view is disputed by Luciano Centini, manager of employee relations at the Berol Corp. in Danbury, Conn., who says refunds can save more than deductibles and co-payments can while not discouraging employees from seeking necessary care.

Berol has had a refund system similar to the Mendocino plan, which Mr. Centini says has saved his company \$300,000 since its introduction in July 1981. The self-insured health care plan is non-contributory and, like the Mendocino plan, the company sets aside \$500 for each employee at the beginning of the plan year. During the year, each employee's medical

claims are deducted from his or her pot.

However, funds remaining are refunded to the employee at the end of the year, unlike in Mendocino where refunds are only made when the employee leaves the school district.

"We've had that criticism (that people won't seek necessary care) since we implemented our plan three years ago," Mr. Centini said. "We've had three years experience and we found that's not the case."

Mr. Centini says employee attitude surveys that have been taken periodically since plan began "indicate that people have changed their behavior in the desired direction."

But along with praising the refund system, Mr. Centini's warns benefit managers not to ignore the key ingredient in his recipe for success—a healthy dose of education.

"We have had a very aggressive education program on teaching employees how to be good consumers of health care," he said. "I wouldn't recommend doing a plan such as ours without the educational aspect. I don't think it would be successful."

Visiting health care professionals lecture Berol employees on stress, nutrition and disease prevention. Employees also have been given tips on how to pick a good doctor and how to balance their diets.

And, the Berol plan encourages them to take care of their health by covering preventive care like physical examinations, immunizations and well baby care, Mr. Centini said.

Although Judy Goulette, a partner at Hewitt Associates in Chicago, has reservations about refund systems, she applauds the educational approach Berol uses.

And, despite her reservations, Ms. Goulette says that Mr. Aycock's plan might be at least worth a try.

"There's really no one perfect answer (to rising health care costs)," Ms. Goulette said. "We're all struggling for the 10 best answers."

## Lloyd's considers switching currency base to U.S. dollar

Continued from page 2

Also, the council agreed that all Lloyd's members' financial status should be reviewed this year. Previously, a member's financial condition was only formally reviewed once every four years.

Among other recommendations in the report that are still under consideration are:

- There should be no limitation on the number of new members elected each year.
- The maximum overall pre-

mium limit, currently 600,000 pounds (\$672,000) for each member, should be abolished.

- All members should be treated equally, although vocational members—those who work in the Lloyd's market and are sometimes financed by their agencies—will still be allowed.

- The current requirement that overseas members must provide their deposit by letters of credit or bank guarantee should be abolished.

## Salem trial begins in Houston

HOUSTON—The Department of Justice has begun its trial against Frederick Ed Soudan and two other men for their alleged involvement in the scuttling of the crude oil carrier Salem and the theft of \$56 million of oil from Shell International Petroleum Co. Ltd.

The three men—Mr. Soudan, James Hillary Shorrock and Abdul Wahab Al Ghazou—face various criminal charges, including conspiracy, perjury, wire and mail fraud and violation of transportation and interstate commerce laws.

The trial is being held in the U.S. District Court in Houston.

Last October, the Justice Depart-

ment tried to avoid going to trial by plea-bargaining with the defendants, who agreed to plead guilty to certain charges if their sentences were reduced (BI, Oct. 22, 1984).

However, on Dec. 2 in the Houston court, Judge Carol O. Bue Jr. rejected the terms of the plea bargain, says Joseph P. Covington, a federal prosecutor in Washington.

Mr. Soudan could face up to 18 years in prison if he is found guilty.

The case involves the 1979 scuttling of the crude oil carrier South Sun, whose name was changed to Salem, after 180,000 tons of crude oil owned by Shell were allegedly sold to SFF Assn. Ltd., a government-owned firm in South Africa. ■

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Jan 28	Jan 15
Feb 4	Jan 23
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Mar 4	Feb 20
Mar 11	Feb 27
Mar 18	Mar 5
Mar 25	Mar 13
Apr 1	Mar 20
Apr 8	Mar 27
Apr 15	Apr 2
Apr 22	Apr 9
Apr 29	Apr 16
May 6	Apr 24
May 13	May 1
May 20	May 8
May 27	May 14
Jun 3	May 21
Jun 10	May 29
Jun 17	Jun 5
Jun 24	Jun 11
Jul 1	Jun 19
Jul 8	Jun 25
Jul 15	Jul 3
Jul 22	Jul 9
Jul 29	Jul 17

## D&O coverage increases

Continued from page 1

Eighty-eight percent of the respondents were business corporations and 12% were educational institutions or hospitals.

The authoritative report, which appeared annually through 1980, has been published every two years since 1982.

"While D&O liability insurance remains much more prevalent among large corporations than small ones, there is a steady growth in the purchase of D&O coverage by smaller organizations," the survey notes.

For example, companies with less than \$25 million in assets reported the greatest increase in prevalence of D&O insurance.

Sixty-two percent of these entities reported having D&O coverage in 1984, compared with 56% in 1982 and 50% in 1980, according to the report. However, the report does caution that the selectivity of sampling techniques probably results in an overstatement of D&O coverage for small organizations.

The survey shows that the prevalence of D&O insurance rises with the size of the company. For example, 97% of the companies with \$1 billion or more in assets reported having D&O coverage, the same percentage reported in 1982 and an increase of 4% since 1980.

In addition, D&O coverage was reported by 82% of the companies with \$25 million to \$99 million in assets, 93% of those with \$100 million to \$399 million in assets and 92% of those with \$400 million to \$999 million in assets.

Closely held companies, when compared with New York Stock Exchange members, have exhibited the greatest growth in carrying D&O coverage over the 10-year period from 1974-84, the survey notes.

In 1984, 64% of the closely held companies surveyed reported having D&O coverage compared with only 40% in 1980 and 23% in 1974. In contrast, 98% of the NYSE-listed companies surveyed reported having D&O coverage in 1984, compared with 96% in 1980 and 76% in 1974.

Ninety-one percent of the mutual companies surveyed had D&O coverage in 1984, compared with 88% in 1980 and 36% in 1974.

Ninety-six percent of the U.S. hospitals participating in the study carried D&O insurance in 1984, while 78% of the participating schools had the coverage.

Meanwhile, D&O policy limits increased dramatically from 1982 to 1984.

While the average increase in policy limits from 1982 to 1984 was 45%, very large companies with assets of \$1 billion to \$2 billion reported increasing their limits by an average 56% to \$31.3 million from \$20.1 million in 1982. This was the highest increase reported among the various-sized corporations surveyed (see chart, page 1).

Medium-sized companies with \$100 million to \$400 million in assets reported the smallest increase—27%—in limits to \$16.6 million in 1984 compared with \$13 million in 1982.

Both the largest companies surveyed—those with more than \$2 billion in assets—and the smallest surveyed—those with assets under \$25 million—reported a 46% average increase in their D&O policy limits in 1984 compared with 1982.

The largest companies' limits rose to an average of \$48.6 million in 1984, compared with \$33.4 million in 1982, while the limits of the smallest companies rose to \$6 million from \$4.2 million.

The survey also shows a dramatic increase in the number of companies purchasing limits of \$50 million or more.

In 1984, 211 of the surveyed companies said their limits were \$50 million or more, compared with 127 in 1982 and only 37 in 1980.

Along with the increasing limits, deductibles for both the corporations' D&O coverage and personal coverage for officers and directors continued to decline. Thirty-one of the surveyed companies reported no deductible at all, while another 56 said they paid no deductible on personal coverage but did on the corporate reimbursement portion of the policy.

Despite the additional coverage the surveyed companies received through both higher limits and lower deductibles, they paid much less for 1984 coverage purchased before the middle of last year, when the market began to tighten, than they did in 1982 and 1980.

For example, companies that purchased primary policies with \$20 million limits in 1984 paid an average of \$41,867, compared with \$55,110 in 1982 and \$102,350 in 1980.

For primary limits of \$10 million, the surveyed companies paid an average of \$11,667 in 1984, compared with \$15,024 in 1982 and \$21,940 in 1980. For primary limits of \$5 million, the surveyed companies paid \$6,004 in 1984, \$10,773 in 1982 and \$14,554 in 1980.

The cost of excess insurance for 1984 policies ranged from a high of \$1,087 per \$1 million of coverage for policies under which excess coverage

## AIG largest D&O insurer: Study

"The 1984 Directors and Officers and Fiduciary Liability Survey" by The Wyatt Co. also identifies the largest underwriters of D&O coverage for U.S. corporations as of May 1984 when the survey data was compiled.

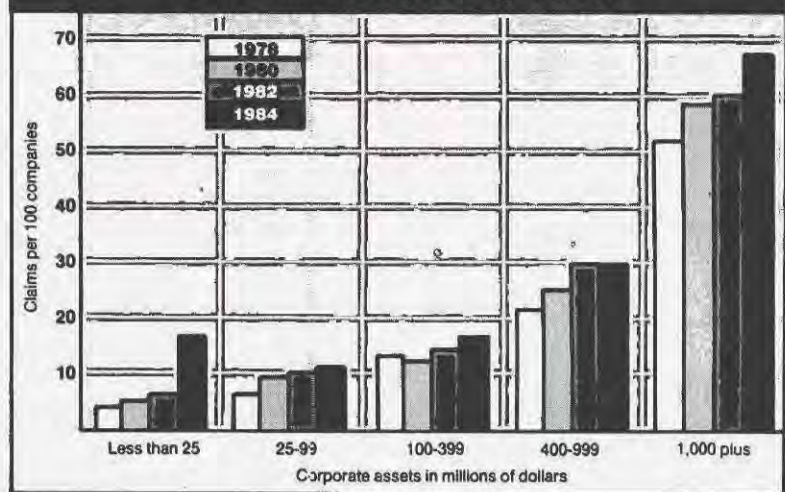
Based on premium volume generated, the D&O insurers most often tapped by U.S. corporations for primary and excess coverage are New York-based American International Group Inc., with 35% of the market; Chubb Corp., largely through Federal Insurance Co. in Short Hills, N.J., 14%; Continental Corp., mainly through Harbor Insurance Co. in Los Angeles, 11%; Chicago-based CNA Financial Corp., which purchased MGIC Indemnity Corp.'s D&O business in November 1983, 9%; Crum & Forster, principally through L.W. Biegler Profit Center in Chicago, 8%; Lloyd's of London underwriters, 7%; and First State Insurance Co. of Boston, 3%. Other smaller markets account for the rest of the market.

Chubb's ranking as the second-largest D&O insurer is perhaps most notable. The company, which was not listed among the leading D&O underwriters in earlier surveys, shot up into sixth place in 1982 and then moved to second last year. Wyatt attributes the company's rise to its aggressive marketing techniques and its new combination policy, which packages D&O with fiduciary, crime and kidnap/ransom liability coverages.

However, some information on the insurers' market share apparently is out of date.

For example, CNA may no longer be one of the five top markets. The company recently dissolved its relationship with underwriting manager Stewart Smith East Inc., which had contractual rights to a significant portion of CNA's business. That will now be placed with Forum Insurance Co., an affiliate of Montgomery Ward Insurance Co. in Schaumburg, Ill. (BI, Dec. 17, 1984). CNA will begin writing its own D&O policies in-house on Feb. 1.

## D&O claim frequency trends



attaches at \$5 million to a low of \$303 per \$1 million of coverage when the excess coverage attaches at \$75 million.

Although D&O insurance limits available have shrunk since mid-1984 while rates have increased anywhere from 15% to 50% or more, the survey is still a valuable tool for risk managers concerned with arranging D&O coverage properly because of the wealth of detailed information contained about claims activity and policies, says Warren G. Brockmeier, vp of risk management services for Wyatt, who spearheaded the D&O survey.

He admits that the premiums cited in the report are "exceedingly out of date" and that capacity has dwindled since Wyatt received survey responses between March and May of 1984.

Mr. Brockmeier predicts that companies that now have D&O policy limits of more than \$200 million will have trouble maintaining that coverage at renewals this year and that businesses with \$100 million will almost certainly have to pay higher rates to keep those limits.

A significant decrease in limits may be of concern to the companies affected because they are seeing more D&O suits filed against them and their cost of disposing of them is increasing, too.

After reporting a leveling out of D&O claims in the 1980 and 1982 survey, this year Wyatt reports that the frequency of claims is increasing at a rate of about 10% compared with only 6.7% in 1982. The 10% rate of increase is still much better than the average annual increase of 19% reported during the eight surveys preceding 1982.

Reporting the greatest increase in claims frequency in 1984 were companies with assets of less than \$25 million. The number of D&O claims per 100 companies in that category almost tripled to 17 in 1984 from only 6 in 1982 (see chart). Companies with \$1 billion or more in assets experienced the second-largest increase in frequency of claims in 1984 compared with 1982. These businesses recorded 67 D&O claims per 100 companies, up from 60 claims per 100 companies in 1982, according to the report.

However, claims for larger corporations with assets exceeding \$1 billion have only increased at a 6% rate per year, indicating that the increase in the overall trend is due to increased claims activity in smaller companies, the report notes.

In general, diversified companies experience a 90% higher frequency of D&O claims, and are 60% more likely to experience one, than their non-diversified business counterparts, the study states.

Diversified companies have a greater exposure to D&O claims "simply because they are into more activities," Mr. Brockmeier says. "Non-diversified companies tend to be more conservatively operated, in a business they're comfortable with, and the shareholders know what they're getting."

In the 1984 survey, 236 of the 1,269 U.S. companies surveyed reported a total of 444 claims, while in the 1982 survey, 300 of 1,979 companies reported 515 claims.

The rate of susceptibility to a D&O claim rose to 18.6% in 1984 compared with 15.2% in 1982. The survey cautions against direct comparisons here because of the slightly different sample of companies in the two surveys.

Besides seeing more claims, companies are paying more to dispose of these claims.

The average defense costs for both open and closed claims in 1984 was \$461,000, compared with \$365,300 in 1982.

The average D&O settlement or award in the 1984 survey, excluding legal fees, was \$1.3 million. For all claims, including those closed without payment, the average cost was \$583,000.

With an average settlement or award of \$583,000 plus average legal costs of \$461,000, the overall average cost of a D&O claim was \$1.04 million in 1984. Adjusted for inflation, this figure becomes \$1.62 million compared with \$1.34 million in 1982.

The largest settlement reported was \$35 million for a claim of wrongful and unilateral breach of contract brought by a party in a business relationship.

The survey points out that educational institutions "exhibit a higher susceptibility and frequency to claims than business corporations." And they spend about \$150,000 defending each open D&O claim.

"Our conclusion is that roughly a third as much need be spent for defense of education institution claims as U.S. D&O corporate claims," the report says.

The major allegation behind D&O claims was misleading representation, which triggered about one-fourth of the identifiable claims reported, or about 102 claims. Four other frequent allegations, in order of incidence, were: conspiracy to defraud; breach of duty to minority stockholders; failure to honor an employment contract; and discrimination or violation of civil rights.

As expected, the most common source of D&O claims remains shareholders, who brought 163 claims, just over one-third of the actions reported. Employees or former employees brought 86 D&O claims, and customers brought 79. Governmental agencies, prior owners of acquired property and competitors were sources of other action.

A copy of the survey's 58-page summary is free to participants and available for \$100 to non-participants. Those who took part in the survey can obtain a comprehensive report and a D&O policy analysis for \$100. Non-participants can obtain these two publications for \$200. For information, contact Warren G. Brockmeier, The Wyatt Co.; Sears Tower, Suite 5600; Chicago, Ill. 60606; 312-876-2000.

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# Fiduciary liability claims also increasing

Fiduciary liability claims that arise from the administration of employee benefit plans are increasing, according to the "The 1984 Wyatt Directors & Officers and Fiduciary Liability Survey."

The survey shows that companies were 51% more likely to be faced with a fiduciary claim in 1984 compared with 1982, while the number of fiduciary claims rose by 65% over the two-year period.

Since the passage of the Employee Retirement Income Security Act in 1974, U.S. companies with employee benefit plans have been prey to allegations of fiduciary liability against directors, officers, employees, the sponsoring corporation or the plan itself.

The survey points out, however, that the number of fiduciary claims against companies is expected to increase as the post-ERISA period grows.

Wyatt had earlier predicted a 30% increase in 1984 over 1982. It points out the larger 51% increase is probably due to several factors, including that the 1984 sampling includes a heavier concentration of large companies, which traditionally experience more fiduciary claims.

Despite such discrepancies, Wyatt still concludes that the rate of increase in fiduciary claims is at least as high as the 10% increase reported in D&O claims between 1982 and 1984 (see story, page 1).

Large companies with benefit plan assets of \$100 million or more reported 21 claims per 100 com-

## Study examines D&O in Canada

While stockholders traditionally have been the principal source of all corporate directors and officers claims in the United States and Canada, the most recent D&O survey by The Wyatt Co. shows that customers are now filing more claims against directors and officers of Canadian businesses than any other type of claimant.

Customers were the source of 38% of Canadian D&O claims, followed by stockholders, 27%; employees or former employees, 13%; and creditors, 5%, according to "The 1984 Wyatt Directors & Officers and Fiduciary Liability Survey."

"Claims brought by customers were indicated by many different companies, not just one company with a multitude of claims," the survey reports.

However, the authors state: "We cannot conclude whether this is an indication of all Canadian claims or just a sampling phenomenon in our survey."

Wyatt queried 201 Canadian entities from 15 different provinces. Of these, 186 were businesses and 15 were schools or hospitals.

Of the 186 companies surveyed, 16 reported a total of 37 D&O claims between 1975 and 1983, up from the 29 claims that were reported by 21 companies in the survey's 1982 edition (*BI*, Nov. 22, 1982).

Directors and officers of Canadian operations see only 60% as many D&O claims as their U.S. counterparts, according to the survey. And, the severity of Canadian claims is about one-third the severity of those filed in the United States.

The insurers that write the most primary D&O coverage in Canada are New York-based American International Group Inc., with 24% of the market; Chubb Corp., 19%; and Gestas, 13%.

Lloyd's of London insurers write excess D&O policies for 27% of the Canadian market, more than any other underwriter, the report shows.

panies in 1984, compared with 14 claims per 100 companies in 1982.

In contrast, small companies with less than \$5 million in plan assets reported only two claims per 100 companies in 1984, and companies with \$5 million to \$24 million in plan assets reported only four claims per 100 companies. The number of claims against companies with less than \$5 million in plan assets was only one per 100 companies in 1982, while companies with plan assets of \$5 million to \$24 million reported three claims per 100 companies in 1982.

Companies with plan assets of \$25 million to \$100 million actually reported a decline in claims per 100 companies to six from nine in 1982.

Of the 1,451 U.S. businesses surveyed, 81 reported a total of 118 fiduciary liability claims, up from

the 97 claims that 73 companies reported in 1982.

While employers with large plans may be hit with the most claims, they aren't necessarily hit with the largest claims.

For companies with plan assets of \$25 million to \$99 million, half of their claimants demand more than \$200,000 in damages.

In contrast, for companies with plan assets of \$100 million or more, only 30% of claimants seek more than \$200,000, according to the report.

Neither category made total payments near that amount, however. In the end, only about one-quarter of the claims received by these two categories resulted in awards of more than \$200,000, the report indicates.

The major source of fiduciary

claims, 93%, continues to be employees, former employees or their families, according to the survey.

The most common allegation, which appeared in 66% of all claims reported, charged denial of benefits. That is followed by claims alleging administrative error in benefit plans, improper advice or counsel and misleading representation.

The survey also notes a trend among companies to purchase higher limits of fiduciary liability coverage, which covers the fiduciaries of a company's pension, profit-sharing or other employee benefit plans against liability, including defense costs, stemming from their role as fiduciaries.

The average limit reported in the 1984 survey soared 49% to \$12.5 million from \$8.4 million in 1982.

The survey also shows that 47% of the companies with fiduciary liability coverage had limits of \$10 million or more in 1984, compared with 35% in 1982 and 27% in 1980. Also, 51 companies now report limits of \$50 million or more, up from only 29 companies in 1982.

Although a \$1 million deductible was reported by one company, 56% of the companies reported that their coverage was written on a first-dollar basis and 33% have only a \$1,000 deductible.

Three insurance companies underwrite 70% of the primary fiduciary liability policies in the United States, according to the study. They are New York-based American International Group Inc., with 28% of the market; Chubb Corp., with 25%; and Aetna Casualty & Surety Co. with 17%. ■

# HOT WORK FIRES

**In a Recent 6-month Period Three Major Industrial Facilities** together sustained over \$37 million worth of property losses due to cutting and welding activities. In addition, several buildings in a major East Coast city were similarly damaged. In each case it was alleged that the fires were started by outside contractors. Here are some details on these incidents, which could have been controlled:

**\$20 Million.** During modernization of a large warehouse, one of the sprinkler systems was shut off while a new system was being installed. Sparks from a **cutting torch** evidently ignited some of the product stored in the warehouse. The fire spread to other buildings. Firefighters finally brought it under control more than nine hours later.

**\$12 Million.** This time sparks from a **welding operation** ignited stored product. The facility fire brigade arrived within minutes. However, winds of 20 miles per hour fanned the fire which spread to other parts of the facility and overpowered the sprinkler system.

**\$5 Million.** Sparks from an **arc welder** ignited highly combustible raw materials that were stored in an uncompleted building. The fire quickly spread. The fire department got it under control almost four hours later.

**25,000 Evacuees.** Sparks from a **welder's torch** allegedly touched off a fire that eventually involved 18 city buildings and forced the evacuation of an estimated 25,000 people from surrounding offices and stores. According to newspaper reports, the fire began when sparks from a propane torch dropped down an elevator shaft and ignited rubbish and debris in the basement of a building that was being renovated.

**A 1979-83 Survey of Cutting and Welding Losses**, conducted by Industrial Risk Insurers, reveals that outside contractors were major contributing factors in 25% of all the cutting and welding losses studied. Even more significantly, this 25% accounted for over 92% of the property damage loss dollars. IRI's 14-part OVERVIEW program is one way to help control this situation. Section 9, Hot Work, and Section 1, Impairment Handling should be of particular interest. Both sections include an Introduction, a Statement of the Problem, an Action Plan, and appropriate Background information.

The other 12 sections of OVERVIEW include Smoking Regulations, Maintenance, Employee Training, New Construction, Insurance Recommendations, Pre-Emergency Planning, Hazardous Materials, Loss Prevention Inspection, Surveillance, Fire Equipment Inspection, Hazard Evaluation, and Housekeeping. For a complimentary copy of the 6-page descriptive OVERVIEW brochure, contact Mrs. P.A. Sasso, IRI, 85 Woodland Street, Hartford, CT 06102, area code (203) 525-2601. Learn how to minimize or prevent Hot Work Fires before they begin.

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**Business Insurance Circulation Breakdown\***

**Commercial Consumers**

**Administrative Management:** owners, presidents, vps, etc. 5,357

**Financial Management:** chief financial officers, vps of finance, secretaries, treasurers, etc. 9,876

**Insurance Management:** vps, directors, managers of insurance, risk, benefits compensation, safety, security, etc. 7,254

**Associations** 1,069

**Government, Unions**

**Educational Institutions** 860

**Commercial Consumers**

**Sub-Total** 24,416

Insurance Agents & Brokers 9443

Insurance Cos. 5636

Financial Institutions 403

Actuaries, Attorneys, Adjusters, Appraisers & Consultants 3220

Others allied to the field 1127

**TOTAL** 44,245

\*Source: Business/Occupational breakdown of qualified circulation, May 7, 1984 issue, as submitted to BPA for June 1984, BPA Publisher's Statement.

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## update

## High court to rule on RICO use

Continued from page 2

in the wake of the Reserve Insurance Co. insolvency and litigation by Universal Marine Insurance Co. over reinsurance transactions.

The case before the Supreme Court involves whether borrowers could use RICO to sue a Chicago bank for fraud because it allegedly miscalculated an interest rate it charged borrowers.

## Baldwin-United to settle claims

CINCINNATI—Baldwin-United Corp. agreed last week to pay about \$170 million to settle claims by insurance regulators in Arkansas and Indiana.

The settlement is a first step toward setting up a fund to boost the 5.5% annual interest rate being paid to holders of Baldwin's single-premium, deferred annuities. The agreement is must be approved by the states' courts and the U.S. Bankruptcy Court in Cincinnati, where Baldwin is in reorganization.

Insurance commissioners in Arkansas and Indiana took control of six Baldwin insurance entities in 1983, after determining that they could not meet their obligations (BI, July 4, 1983).

The two-phase settlement calls for Baldwin to give up any ownership rights to more than \$3 billion of assets owned by the six insurance entities and to try to settle claims by the Internal Revenue Service that Baldwin owes \$400 million in back taxes.

In the plan's second stage, Baldwin would pay the six insurance entities approximately \$170 million from the sales of certain assets, including the Mortgage Guarantee Insurance Co., and resolution of IRS and creditors' claims, the spokeswoman said.

In other action, bankruptcy court examiner David Greer recommended lawsuits against Morley P. Thompson, Baldwin's former chairman, and the company's former board. Mr. Greer told the court last week that he didn't find evidence of fraud and dishonesty for personal gain by Mr. Thompson or the board, but that he did find breaches of fiduciary duty.

Mr. Greer, a Dayton, Ohio, lawyer, also said investigations would be justified into possible lawsuits against Merrill Lynch & Co.; Peat, Marwick, Mitchell & Co.; and executives of MGIC Investment Corp., which Baldwin acquired in 1982.

Merrill Lynch helped finance some business for Baldwin and sold thousands of Baldwin annuities. Mr. Greer's report said the Baldwin board took the advice of Peat Marwick instead of listening to some directors who suspected that Baldwin-United was in trouble.

Mr. Greer also suggested further investigation into insider trading by former Baldwin officials.

## Abortion clinics lose coverage

Continued from page 3

America decided not to renew the coverage it wrote for the Yakima clinic when the coverage expired in May "even though we didn't have any problems here," says Ms. Whipple.

General Accident was "extremely fair in trying to help, but they just couldn't stay on the risk," Ms. Shaw of Junker, Shaw notes.

The Yakima clinic eventually purchased coverage with Great Southwest Surplus Lines Insurance Co. in Scottsdale, Ariz. The coverage was placed by Junker, Shaw through Cochrane Griffin & Co. Inc., a wholesale broker in Bellevue, Wash.

In San Diego, a facility operated by the Birth Control Institute, a non-profit family planning service that was the target of an arson last September, lost its coverage written by National Fire Insurance Co. of Hartford, a CNA Financial Corp. unit, says Dr. Warren Roberts, BCI's executive director.

The insurer gave the facility only three days' notice of the cancellation, he says.

Dr. Roberts says he is still trying to settle losses from the incident with the Chicago-based underwriter, though the facility has since partially reopened.

CNA officials would not comment because the claims are still pending.

The coverage written by CNA for the BCI clinic in San Diego and another in Anaheim, Calif., included liability limits of \$500,000 per occurrence and \$1 million aggregate at each location, as well as property and business interruption coverage. The coverage for each facility cost about \$1,000 annually,

**'Companies are just not willing to write the risk at a standard rate,' explains Barbara Shaw.**

Dr. Roberts says.

Although he will not discuss the specifics of his current insurance program, Dr. Roberts says the new coverage costs about 400% more than the CNA coverage, though he adds limits were increased about by 25%.

Some clinics have also had their medical malpractice insurance canceled upon renewal.

The Home Insurance Co. in September stopped renewing the medical malpractice policies it wrote for abortion facilities through a program sponsored by the National Abortion Federation.

The decision will eventually affect about 160 clinics. The 40 clinics whose coverage has expired since September have been picked up by Constitution State Insurance Co., according to the NAF's Ms. Schoenbrun.

The Home decided not to renew the association program as the policies expire because the insurer doesn't generally write medical malpractice risks, not because of any particular risk associated with abortion facilities, according to a spokesman for the New York-based insurer.

Not all clinics that have been vandalized have lost their coverage. The Concerned Womens Center in Houston, which was the site

of an attempted arson two months ago, still retains its property and liability coverage written by Austin-based Texas Medical Liability Trust, says Dr. Howard Novick, the center's owner.

The coverage consists of bodily injury coverage with a \$200,000 limit; \$50,000 of property contents coverage; and medical malpractice coverage with a \$500,000 per-occurrence and \$1.5 million annual aggregate limit. The center has been insured by the Texas Medical Liability Trust for five years and pays about \$17,000 annually in premium, according to Dr. Novick.

Agents and clinic operators agree that if the number of attacks against clinics declines, underwriters may be more likely to write coverage for abortion facilities.

"I think there'll be a lot of problems for clinics getting insurance in the next three to five years. But when all of this dies down, I think insurance companies will start insuring abortion clinics again. This is just temporary," suggests Gail Frances, president of Metro Medical & Womens Center in Wheaton, Md.

Metro Medical was "totally wiped out, just destroyed" by a bomb on Nov. 19, but St. Paul Fire & Marine Insurance Co., its property insurer, did not cancel the office contents coverage, Ms. Frances says.

However, she notes the \$80,000 limit of the policy won't cover the estimated \$200,000 in property that the center lost in the blast. She says Metro Medical is expected to reopen in about six months; in the meantime the center is sharing space with another local women's center.

## Right to defense coverage strengthened

Continued from page 2

of copyright or of property rights or title or of slogan; piracy, plagiarism or unfair competition or idea misappropriation under implied contract; or any invasion of rights or privacy committed or alleged to have been committed in any advertisement, publicity article, broadcast or telecast out of the insured's advertising activities."

However, the policies excluded coverage arising out of the "incorrect description of any article or commodity, or any claim or suit based upon or arising out of alleged false, misleading, deceptive, fraudulent or misrepresenting advertising or to any claim or suit for unfair competition based thereon."

The policies also excluded suits brought "because of an act committed by the insured with knowledge the same constituted any of the hazards insured by this policy."

Seaboard contended that Gillette's and Thompson's actions came within the exclusions, since Seaboard alleged that the companies made false statements about the Alberto-Culver product and that they knew they were engaging in acts covered by the policies.

Because of the policy exclusions, Seaboard refused to provide defense or indemnification after the Alberto-Culver suit was filed or following the 1979 settlement.

Soon after the settlement, Seaboard sued in New York court, seeking a judgment that it properly refused to defend and had no duty to pay defense costs or indemnity for the settlement.

Seaboard attorney James F. Rittinger said Seaboard had to be able to look beyond the complaint and the policy to Gillette's and Thompson's actions to prove that the companies knew they were engaging in acts covered by the policies, thus triggering the exclusions.

Seaboard contended that a trial or hearing should be held to look at

these outside factors and, therefore, at whether it should defend.

Gillette and Thompson, however, contended the court should not look beyond the allegations of the lawsuit and the insurance policy to determine Seaboard's obligations, said John M. Friedman Jr., the companies' attorney.

Both the trial court and an appellate court agreed with Gillette and Thompson, ruling that Seaboard had a duty to defend. The Court of Appeals, the state's highest court, affirmed those decisions.

Relying on prior case law, the court noted the broad obligations of insurers to defend.

"The duty to defend arises whenever the allegations in a complaint against the insured fall within the scope of the risks undertaken by the insurer, regardless of how false or groundless those allegations might be," the court said.

"The duty is not contingent on the insurer's ultimate duty to indemnify... nor is it material that the complaint against the insured asserts additional claims which fall outside the policy's general coverage or within its exclusionary provisions."

The court also said an insurer wishing to exclude coverage from its policy obligations must do so "in clear and unmistakable language."

"Here, it cannot be said that the provisions of the insurance policies clearly negated Seaboard's duty to defend against every allegation asserted in Alberto's complaint."

Moreover, some of the claims against Gillette and Thompson fall within the general provisions of the policies and are not unambiguously excluded, the court added.

The policy provisions explicitly require the duty to defend "any suit seeking damages" for any of the covered causes at the time the suit is filed.

"The veracity of the allegations and the ultimate liability of Gillette

and Thompson, as well as the ultimate obligation of Seaboard 'to pay by reason of liability,' are irrelevant to its duty to defend."

If Seaboard is to be relieved of its duty to defend, it must show that the allegations of the complaint cast the pleading "solely and entirely" within the policy exclusions, the court said, adding that none of the allegations in Alberto-Culver's complaint can be said to meet that criterion.

Gillette's and Thompson's attorney Mr. Friedman, with the New York firm of Dewey, Ballantine, Bushby, Palmer & Wood, characterized the decision as "not a shift in policy" but one that pulls together many prior case rulings on the duty to defend.

The ruling should be a big help to policyholders and insurers in determining an insurer's defense obligations, he added.

However, Seaboard's attorney Mr. Rittinger, with the New York firm of Satterlee & Stephens, called the opinion a "very, very adverse decision to insurance companies."

Some issues still remain in the case, including how many occurrences took place. Seaboard contends that the broadcast of the commercials during the mid-1970s arose out of the same occurrence, thus triggering only one policy for limits of \$1 million.

Gillette and Thompson, however, contend the occurrence took place over several years during the mid-'70s, triggering several policy years to cover the settlement.

Under the more than \$4 million settlement with Alberto, Gillette agreed to pay about three times as much as Thompson.

Mr. Friedman also said Gillette has excess insurance underwritten by Commercial Union Insurance Co., but added that whether that coverage will respond depends on the outcome of the continuing litigation with Seaboard.

## Lloyd's syndicates face huge loss

Continued from page 2

However, Spicer & White says it does not yet know the types of all the risks written in the U.S. The report did not name the MGAs involved.

"We are experiencing difficulty in obtaining detailed records from various agents in the United States about the exact nature, date of inception and expiry of these policies. Because information about the underwriting under these binding authorities is not adequate, it is difficult to predict the claim settlement," says the report.

So far, Spicer & White members have paid about half of the estimated losses through three cash calls made by the agent in 1983 and 1984, said a Spicer & White spokesman.

Sources say Robert Bishop Adjusters Ltd. has been hired by Spicer & White to investigate the losses.

Spicer & White says in the report it is now trying to recover funds from reinsurers to pay the losses. But, if reinsurance recoveries do not fully pay the losses, Lloyd's members will have to pay the debt.

The syndicate members, who include tennis star Virginia Wade, have been aware of large losses since the syndicates stopped underwriting on Dec. 31, 1982 (BI, March 19, 1984).

Spicer & White said in a detailed report released in October 1983 that the syndicates' losses totaled about 13 million pounds (about \$14.5 million).

However, the losses have grown because the size of the claims has increased as the dollar grows stronger in comparison with the pound, Spicer & White says. About 70% of the syndicates' business was in dollars (see story, page 2).

In addition, the exact amount of the losses is not yet known because the syndicates' 1982 accounts are just closing under the Lloyd's three-year accounting system.

However, the members will be asked again in May to pay no less than 40,000 pounds for each 20,000 pounds of premium underwritten after all syndicate accounts are closed, the report says.

The Spicer & White losses are now nearly as substantial as those incurred by the Sasse syndicate in 1978 (BI, Feb. 6, 1978).

At that time, 110 Sasse underwriting members were asked to pay 21 million pounds (\$42 million at the time) of losses stemming from substandard fire risks in New York. The risks were bound for the syndicate by a Florida managing general agency.

Lloyd's bailed out the Sasse syndicate members by imposing a charge to all Lloyd's members to pay for the losses (BI, May 30, 1983).

Lloyd's Chief Executive Ian Hay Davison says Lloyd's doesn't intend to provide financial assistance to Spicer & White members.

But, Spicer & White's parent company, Carter Wilkes & Fane (Holdings) Ltd., as well as Lloyd's broker Willis Faber, P.L.C., the underwriting agency's ultimate holding company since April 12, 1982, plan to provide loans to the members.

"If we are successful, this will relieve the burden of the cash call until names receive tax refunds and, where applicable, recoveries on their personal stop-loss policies and the underwriter has secured for the reinsurance recoveries for the syndicate," Spicer & White says.

## Liquidation looms for Ideal Mutual

Continued from page 1

plied Risk Funding Services, which specializes in captive insurance and fronting programs.

"Everyone looks at New York," Mr. Allen adds.

But the Insurance Department strongly denies Ideal was put into rehabilitation to serve as an example to others. "The last thing any regulator wants to do is lose a company," said the New York department spokesman. "If anything, regulators hold onto companies longer than they should."

If the department obtains a court order to liquidate Ideal Mutual, all the insurer's assets will be disposed of and proceeds will be used to pay claims, with New York policyholders given first priority.

The New York Insurance Department and Ideal Mutual policyholders whose risks were reinsured with the policyholders' insurance subsidiaries through fronting arrangements are discussing whether these policyholders can assume their share of Ideal's liabilities or transfer them to other insurers.

If these fronting clients' liabilities are not transferred from Ideal Mutual, state guaranty funds will be triggered to pay their claims in addition to those of other policyholders. The guaranty funds will then try to recover from Ideal, which in turn will tap its available reinsurance, including that with captive reinsurers.

Limitations on claims payments under these state funds vary widely.

The New York department's intent to seek liquidation of Ideal Mutual was announced last week at a meeting of New York and other state insurance department officials to discuss liabilities under the states' guaranty funds. Ideal Mutual was admitted in all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands and Canada.

If Ideal Mutual is liquidated, Optimum Insurance Co. of Illinois will remain in rehabilitation. The liquidation is not expected to have any immediate impact on the Illinois insurer, according to an Illinois official.

Optimum Insurance Co. is a subsidiary of Optimum Holding Co., which is owned 51% by Ideal and 49% by the public. Half of Ideal's \$120 million liability for unauthorized reinsurance, according to the New York Insurance Department, is related to Optimum of Illinois' pooling agreement with Ideal.

Ideal Mutual and Optimum In-

surance share premiums, expenses and liabilities on insurance written by both companies on a 51%-49% basis. However, because Optimum Insurance was not admitted in New York, the New York Insurance Department does not recognize Ideal's reinsurance with it.

Ideal Mutual also owns a Bermuda subsidiary, Ideal Insurance Co. (Bermuda) Ltd., which continues to operate. The New York department spokesman says the department can draw on Ideal (Bermuda) assets to pay claims to the extent Ideal has reinsurance with that company.

Ideal Mutual reported \$56,376 in losses recoverable from Ideal (Bermuda) as of Dec. 31, 1983.

No action has been taken by the Bermuda government against Ideal (Bermuda), which also is one of 15 equal shareholders in Corporate Insurance & Reinsurance Ltd., which provides for the pooling of risks of its owners, all insurance subsidiaries of U.S. corporations.

Mr. Allen, who also is a director of CIRCL, said last week that he had not yet discussed with New York officials what impact Ideal's liquidation would have on the Bermuda subsidiary.

He added that the one risk placed by Ideal into CIRCL has been switched by the policyholder's broker to another insurer that is not a CIRCL member. He added that Ideal's pending liquidation will not have any impact on handling of prior claims.

Reinsurers of Ideal Mutual that issued letters of credit to Ideal apparently need not be concerned if Ideal Mutual is liquidated.

If Ideal is liquidated, the letters of credit issued to Ideal and funds on deposit from unauthorized reinsurers will be used only to pay those claims filed against the accounts for which the LOCs were issued and funds deposited, and not for other claims, says the New York department spokesman.

"Those letters of credit are in escrow and can only be used against the writing of that account," he explained.

Many of the letters of credit were submitted by policyholders that used Ideal Mutual as a fronting insurer for their captive insurance subsidiaries. About half of the \$120 million liability imposed by the department examiners for unauthorized reinsurance is related to these fronting programs for captive insurers, primarily located in Bermuda.

Ideal was a leader in providing

fronting programs to corporations. Under a fronting program, an insurer issues an insurance policy to a corporation and then reinsures all or a substantial part of the risk with the policyholders' captive insurer or another insurer designated by the policyholder.

Ideal's former president, Mr. Becker, said the amount of risk retained by Ideal ranged from nothing on some older programs to 20% to 25% on some newer ones.

Fronting programs for corporations using captive insurers accounted for \$49.8 million, or about 22.7% of both Ideal's and Optimum Insurance of Illinois' direct written premiums of \$219.7 million in 1983.

Ideal Mutual's 1983 financial report to the New York Insurance Department shows that funds and letters of credits totaling at least \$58 million were submitted by captive insurers. But, the New York department is charging Ideal with about \$60 million more in liabilities related to these programs because it says the funds and letters of credit issued to Ideal under these fronting programs are insufficient to cover potential losses.

Vincent Laurenzano, the department's assistant chief examiner, did admit previously that the amounts owed by the captives "may be collected at some point." But since the captives are not admitted insurers in New York, the funds believed necessary by the department should be on deposit now or guaranteed by an LOC.

Most, if not all, of these policyholders with fronting programs have already moved their business

from Ideal, according to observers in the market, although these policyholders must still deal with claims being filed against policies issued in the past for which Ideal fronted.

Included among these were captives for Nashville, Tenn.-based Hospital Corp. of America, Archer Daniels Midland Co. in Decatur, Ill., and the New York-based Federation of Jewish Philanthropies.

Ideal also provided fronting programs to:

- St. Pancras Co. Ltd., the captive of the Montvale, N.J.-based Great Atlantic & Pacific Tea Co., for which Ideal reported \$1.9 million in reinsurance recoverable and \$1.5 million in funds on deposit, including a letter of credit. An A&P official would only say that A&P had moved its insurance from Ideal.

- North Star Casualty Insurance Co., the captive of the North Star Mutual Hospital Assurance Co., which is sponsored by the Hospital Assn. of Minneapolis. Ideal reported \$2.9 million in reinsurance recoverable and \$5.5 million in funds on deposit from North Star, including a letter of credit.

Doug Beach, president of North Star Casualty Services, an independent management company, said North Star began a fronting program with Ideal in 1981, but left the insurer about 2½ years ago. Great Global Assurance Co. of Scottsdale, Ariz., is now the fronting insurer.

North Star Casualty Services has employed a law firm to study the Ideal Mutual situation in view of the Insurance Department's deci-

sion to seek liquidation, Mr. Beach said.

- Transportation Security Insurance, the captive of the San Francisco-based Loomis Armored Car Service Inc., a subsidiary of Seattle-based Loomis Corp., which is owned by an Australian company.

Ideal reported \$828,000 in reinsurance recoverable from Transportation Security and \$4.5 million in funds on deposit, including a letter of credit.

- FFH Insurance Co. Ltd., the captive for a group of five New York hospitals, for which Ideal reported \$3.1 million in reinsurance recoverable and \$5 million in funds on deposit, including a letter of credit.

- TRA Insurance Co. Ltd., the captive for the Thoroughbred Racing Assn. based in Lake Success, N.Y. Ideal reported \$1.2 million in reinsurance recoverable and \$2 million in funds on deposit, including a letter of credit.

- AGTOA Insurance Co. Ltd., the captive of the American Greyhound Track Operators Assn. based in North Miami, Fla. Ideal reported \$1.3 million in reinsurance recoverable and \$1.8 million in funds on deposit, including a letter of credit.

- HTA Insurance Co. Ltd., the captive of the Harness Tracks of America. Ideal reported \$1.4 million in reinsurance recoverable and \$1.9 million in funds on deposit, including a letter of credit.

- Health Care Insurance Co. Ltd. in Bermuda, the captive for members of the Health Care Group

Continued on facing page

## Report details Ideal discrepancies

NEW YORK—The New York Insurance Department's report on its triennial examination of Ideal Mutual Insurance Co. details how the department found Ideal insolvent by \$155 million at the time the insurer reported \$12 million in surplus.

The report also criticizes the insurer's record keeping.

Regarding the valuation of liabilities:

- Liability for unauthorized reinsurance, according to Ideal, totaled \$3.3 million, while the department found \$123 million, a \$119.8 million difference. About half is related to Ideal Mutual's pooling agreement with its affiliate Optimum Insurance Co. of Illinois and about half is related to reinsurance ceded to the insurance subsidiaries of policyholders under fronting programs.

- Ideal reported its losses at \$48 million; the Insurance Department said losses totaled \$72 million, a \$23.9 million difference.

- Funds held by the company under reinsurance treaties, according to Ideal, totaled \$45 million, while the Insurance Department said \$54.7 million. The difference is a \$9.7 million loss portfolio transfer of reserves on Dart & Kraft Co.'s insurance programs (BI, Jan. 14).

- Ideal did not provide for any unrecorded premiums; the department established a \$4.1 million provision for unrecorded premiums.

- Loss adjustment expense reserves, according to Ideal, totaled \$4.4 million, but the department said these reserves should be \$6.7 million, a \$2.3 million difference. The biggest discrepancy in any line between the examiner and the company was in workers compensation. The department estimated these expenses at \$3.2 million, which is almost twice the company's workers compensation loss adjustment expense reserves of \$1.8 million.

- A total of \$13.9 million was payable to affiliates according to Ideal; the total was \$15.4 million, according to the Insurance Department. Most of the \$1.5 million difference is attributable to the fact

that Ideal erroneously pooled with Optimum its liability for unauthorized reinsurance with other reinsurers.

- Ideal says it had "other expenses" of \$1.9 million, while the Insurance Department says these expenses total \$2.7 million. "The liability as computed by the company's independent certified public accountant was used in this report," said the Insurance Department.

- Ideal reported no dividends declared and unpaid to policyholders; the Insurance Department says it found \$205,925.

Regarding the valuation of assets:

- Reinsurance recoverable on loss payments totaled \$29.6 million, according to the insurer, while the Insurance Department says only \$17.1 million is recoverable, a \$12.5 million difference.

- Ideal valued its common stocks at \$20.5 million, while the Insurance Department said common stocks were worth \$13.3 million, a \$7.2 million difference.

At issue here are \$1.4 million of stock in Ideal Mutual's Bermuda insurance company subsidiary, \$5.7 million of stock in Optimum Holding Co. and \$71,000 worth of stock invested in Aetna Life & Casualty Insurance Co. The report said that because the company has been found insolvent, no credit could be allowed for insurance company stocks owned.

- "Other assets" totaled \$10.5 million according to Ideal, and \$6.6 million according to the examiner, a \$3.9 million difference. "The asset has been admitted to the extent that supporting documentation and evidence of collectibility was provided by the company," said the report.

Among the items disallowed in this category were amounts due from policyholders under deductibles (\$2.3 million), overdue premiums from Optimum Ideal Managers Inc. (\$585,000), certain contingent commissions (\$529,667), an escrow account in a bank (\$300,000) and an advance to Entertainment Risk Management (\$200,000). The report said the loan, which had not been

paid as of Sept. 30, 1984, was prohibited by New York state law.

- Agents' balances, or uncollected premiums, totaled \$52.4 million, according to the company. However, Insurance Department says agents' balances total only \$51.8 million, a \$624,000 difference. The department said the discrepancy represents overdue premiums the company failed to report at Dec. 31, 1983.

- The Insurance Department did say, however, that Ideal had additional accrued retrospective premiums of \$18.3 million the insurer had not listed as assets. Of this, \$15.7 million was for workers compensation.

As a result of these and other adjustments, the New York examination found Ideal Mutual \$155.3 million short of meeting its liabilities of \$310.6 million.

The report also criticized Ideal Mutual's recordkeeping, stating "it was found that the supporting documentation and audit trails were poor." For instance, the report said:

- The company had about \$47 million in gross premiums with effective dates of 1983 and earlier that were not recorded until 1984.

- Payment schedules were missing for several insureds paying on an installment basis, and there was no control in the posting of cash receipts. As of Dec. 31, 1983, says the report, the company reported about \$10 million in "unapplied cash," which is money that has not been assigned to a specific account.

- Ideal could not provide adequate supporting documentation to verify deductible recoveries due from certain insureds, a miscellaneous receivable and a contingent commission receivable.

- Special statistical data that was prepared by the company for the exam disagreed with loss development schedules reported by the company itself in its 1984 quarterly statements. Ideal was unable to explain or reconcile the differences.

- The company didn't provide the examiners with complete reinsurance contracts, or a complete listing of all reinsurance contracts in force.

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Continued from facing page

Inc. Ideal reported \$1.5 million in reinsurance recoverable and \$1.8 million in funds on deposit, including a letter of credit.

● **Catralco Insurance Co. Ltd.**, the captive for a group of trucking leasing firms. Ideal reported \$1.3 million in reinsurance recoverable and \$1.3 million in funds on deposit, including a letter of credit.

The TRA, AGTOA, HTA, Health Care Insurance and Catralco Insurance captives are all managed by Fred S. James & Co. Inc., which had acted as a broker, says Harry Shuford, a James senior vp in the captive planning division in the broker's New York office.

James switched its clients' business to other insurers in early 1984 as soon as it learned of Ideal Mutual's deteriorating financial condition, he said.

James has discussed the use of the letters of credit with the New York Insurance Department and "they have indicated that as long as the reinsurers honor their commitments under their reinsurance contracts, the letters of credit are secure," according to Mr. Shuford.

Based on that assurance, James is concentrating its efforts on setting up procedures to process claims payments, Mr. Shuford added. James plans to work with the New York Insurance Department's liquidation bureau as well as with other states' guaranty funds, he says.

Another former Ideal policyholder, who said he is also organizing a claims payment facility, added that in some hardship cases, his company is paying workers compensation claims itself immediately.

The risk manager, who asked not to be identified, criticized the Insurance Department for bouncing all claims checks that were outstanding as of the date of the rehabilitation order. "It's been a very embarrassing thing" to some of the checks' recipients, he said.

Stopping the payment of checks was called for under Ideal's order of rehabilitation, which restrained those associated with the insurer from "the further transaction of business or from dealing with or disposing of the assets of the said corporation."

In addition to finding a \$120 million liability for unauthorized reinsurance, the New York Insurance Department cited as another reason for putting Ideal Mutual into rehabilitation the loss of almost \$35 million on insurance written for Ideal Mutual under managing general agency contracts.

Ideal Mutual and Optimum Insurance Co. of Illinois began accepting a larger volume of MGA-produced business in 1982, and by December 1983 MGA-produced business accounted for 43.2% of the \$255 million in gross premiums written by both companies that year.

Market observers said Ideal's rates on its MGA business often beat the competition's.

There were a lot of "extremely low prices," said one broker.

Ideal Mutual's wholly owned MGA, NDS Enterprises in Kansas City, which it purchased in 1982, generated \$33 million in direct and assumed premiums in 1983, and ceded \$29.6 million of this. It was left with net premiums written of \$3.4 million, according to a report which was prepared by a consultant to the New York Insurance Department. Information is not available on any losses.

Ideal also had MGA contracts with unrelated companies, including Alexander & Alexander Services Inc., which had the underwriting pen for product liability insurance for associations, says Richard Lynn, A&A senior vp. The relationship lasted from 1981 to 1984, says Mr. Lynn, who said he could not provide data on premiums or losses.

While some of the policies were large, he said, most were medium-sized or smaller policies.

Other MGAs with whom Ideal did business, according to the New York Insurance Department, included:

● **National Excess Insurance Services**, based in Laguna Hills, Calif., a Corroon & Black Corp. unit formerly known as Global Aviation Insurance Managers. The company's president, Tom Styles, said it had a "long-term relationship" with Ideal that began in the mid-1970s and ended last year. Its business was primarily aviation risks for small planes, explained Mr. Styles, who would not give any information on premiums or losses.

● **Automobile Rental Insurance & Services Inc.**, based in Paoli, Pa., an MGA that insured auto physical damage on rental automobiles.

A spokesman for the company could not be reached for comment.

● **Haddon-Fraser Associates**, based in New York, which is the U.S. manager of Northumberland General Insurance Co. and a member of Toronto-based Ivanhoe Insurance Group. A company official had "no comment."

Mr. Shuford of Fred S. James said many of the James fronting programs were written by James technically acting as an MGA, although in almost all cases rates were negotiated with Ideal Mutual. The broker, he said, was more in the nature of a "program administrator," providing the administrative services Ideal Mutual did not have the staff to provide.

Not all of Ideal Mutual business was captive-fronting programs or produced by MGAs.

One account that generated "several million dollars" in premium annually for several years was written by Ideal under the auspices of the National Sheriffs Assn. which is based in Alexandria, Va., according to Ellen Copeland, the association's director of administra-

tion.

The policy, which ran for six years and expired in October, covered lawsuits against sheriffs. The association's 25,000 members had the option of buying a \$500,000 policy with endorsements available for coverage up to \$1 million.

Most of the reinsurance, she said, was placed with Lloyd's of London underwriters. The broker was Rein Co. in Chevy Chase, Md.

The association is now sending copies of all lawsuits to the New York Insurance Department, in compliance with its directions, said Ms. Copeland.

Other policyholders will be turning to their state's guaranty funds, for which the New York Insurance Department sponsored a meeting last week to discuss Ideal Mutual. In addition to representatives of the guaranty funds around the country, brokers, policyholders and other interested parties also attended.

The meeting provided an opportunity for an "exchange of information," said the department spokesman.

Bruce W. Foudree, Iowa's insurance commissioner and president of the National Assn. of Insurance commissioners, who attended Tuesday's meeting, said, "It seems like everything is being done that can possibly be done at this time."

He said the meeting alleviated the concerns of insurance department officials in 22 states whose guaranty funds will be triggered only if a liquidation order is handed down by the court.

Some guaranty fund officials were worried that the New York department was "letting them drag on," leaving them unable to compensate their policyholders, Mr. Foudree said.

The guaranty funds in the remaining states were triggered in December upon the announcement of Ideal Mutual's rehabilitation.

Larry Coleman, financial services manager for the NAIC, said the meeting was "somewhat premature" because the New York Insurance Department did not have the data ready that the insurance department officials need on claims and policy exposures in their states.

That information is expected to be available this week.

"It is just impossible to have all the information on such short notice," said Mr. Foudree, noting that the data is scattered among agents around the country.

Claims of New York policyholders will be paid out of the state's guaranty fund if Ideal does not have sufficient assets to cover them. Other policyholders must go to their own state's guaranty funds if their claims are not paid.

There is sometimes a question as to which state's guaranty fund should respond, noted Mr. Coleman.

If a company's headquarters, for instance,

is in one state and the risk in another, it could lead to negotiations between the two states as to whose fund should pay claims. Workers compensation, however, is usually paid from the fund of the state where the accident occurred.

The terms of guaranty funds can differ widely. For instance, while New York will pay up to \$1 million per claim, Illinois' limit is \$150,000, says Ken Smith, deputy director of the Illinois Insurance Department's property/casualty division.

New Jersey's guaranty association is authorized to provide coverage for 90 days after a rehabilitation order is issued or until the policy involved expires, whichever is earlier. There is a maximum payment of \$300,000 per claim.

In addition, while some states may pay \$5,000 for the loss of returned premiums, in others, there is "no way" that they can be recovered, notes Charles L. Ruoff, senior vp of property/casualty insurance for Fred S. James.

Joe Martin, chief of the conservation and liquidation division of the California Insurance Department in Los Angeles, says a hearing will be held Jan. 24 to determine whether California can liquidate Ideal's assets in that state. This would follow a conservation order obtained by the Insurance Department on Jan. 8 from Los Angeles Superior Court.

Ideal wrote more than \$25 million in direct written premiums in California in 1983, making the state Ideal's second largest market behind New York.

According to Mr. Smith of the Illinois Insurance Department, Ideal's impending liquidation will not affect Optimum Insurance of Illinois, which was placed into rehabilitation Jan. 4.

"I don't know what direct impact it has at this point," he says, adding it is "pretty clear" Optimum Holding Corp. must be sold to someone for Optimum Insurance to emerge from rehabilitation.

Ideal Mutual's 51% holding in Optimum Holding Corp. is an asset that could be sold as part of the liquidation. Last week, Optimum's stock was trading for less than 25 cents per share.

Robert Perkins, chairman and chief executive of Optimum Holding, Optimum of Illinois' parent company, said he is waiting for the Illinois Insurance Department's evaluation of the insurer's financial condition before making any efforts to raise capital. "It's pretty hard to do when you're trying to estimate what the financial statements are like," he says.

Mr. Smith said he plans to resume claims payments to Optimum of Illinois policyholders within the next two weeks or so. Direct premiums written by Optimum of Illinois in the state, the only one in which it is admitted, total \$19.5 million, primarily for workers compensation insurance.

## BI Industry Stock Report

Insurance Cos.	Jan. 15, 1985				1/9/85 thru 1/15/85				Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)			
	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)											
Aetna Life & Cas Co	NYSE	38.00	4.1	19.5	2.84	6.9	38.25	36.50	1,366.7	United States Fid & Gty Co	NYSE	36.50	2.9	8.5	2.08	7.8	27.25	26.38	605.3
American Bankers Ins Group	OTC	11.50	-2.1	7.1	0.50	4.3	11.88	11.50	186.9	United Svcs Life Ins Co	OTC	28.00	0.9	5.5	1.20	4.3	28.25	27.75	8.9
American General Corp	NYSE	26.00	4.5	9.6	0.90	3.5	26.50*	24.88	1,559.0	USLife Corp	NYSE	34.38	2.2	9.6	1.04	3.0	34.38	32.63	618.9
American Indty Fintl Corp	OTC	15.63	0.0	0.0	1.12	7.2	15.63	15.63	1.1	Washington Natl Corp	NYSE	21.75	3.6	12.0	1.08	5.0	21.75	21.25	78.4
American Intl Group Inc	NYSE	66.13	1.7	12.9	0.44	0.7	67.25	65.38	622.5	Zenith Natl Ins Corp	OTC	13.75	5.8	10.9	0.68	4.9	13.75	13.00	36.5
American Natl Ins Co	OTC	29.63	0.9	8.1	1.08	3.6	29.63	29.38	105.6	INSURANCE COMPANIES				AVERAGE	13.8	3.7			
Aneco Reins Ltd	OTC	1.38	22.2	0.0	0.00	0.0	1.38	1.13	12.3	AGENTS/BROKERS									
Avenco Corp	AMEX	19.50	0.6	10.7	0.60	3.1	19.50	19.13	4.1	Alexander & Alexander Svcs	NYSE	25.38	4.6	281.9	1.00	3.9	25.38*	24.13	453.7
Banks Iowa Inc	OTC	41.50	0.0	13.1	1.56	3.8	41.50	41.50	3.0	Baldwin & Lyons Inc	OTC	45.00	2.3	15.8	0.80	1.8	45.00*	44.00	1.3
Bitco Corp	OTC	11.00	-6.4	2.0	0.40	3.6	11.00	11.00	7.1	Corroon & Black Corp	NYSE	33.00	12.3	19.8	1.00	3.0	33.00*	30.00	264.5
Carolina Cas Ins Co	OTC	3.50	0.0	0.0	0.00	0.0	3.50	3.25	0.0	Crum & H Cos Inc	OTC	20.13	4.5	18.0	0.44	2.2	20.13*	19.38	93.9
Chubb Corp	NYSE	50.75	-1.0	17.8	2.20	4.3	51.00	50.75	864.1	Ewert & Chandler Cos Inc	OTC	11.00	0.0	0.0	0.00	0.0	11.00	11.00	0.3
Combined Intl Corp	NYSE	39.88	2.6	10.1	2.08	5.2	39.88	38.75	226.1	Gallagher Arthur J & Co	OTC	29.75	-0.8	21.2	0.22	0.0	29.75	29.50	36.0
Continental Corp	NYSE	37.50	2.4	107.1	2.60	6.9	37.50*	36.38	382.6	Hall Frank B & Co Inc	NYSE	24.38	3.7	0.0	1.00	4.1	24.38	23.50	386.4
Crawford & Co	OTC	19.75	2.6	12.7	0.66	3.3	19.75*	19.25	10.6	Integrated Res Inc	AMEX	15.25	5.2	5.9	0.00	0.0	15.25	14.63	113.0
Crown Life Ins Co	OTC	118.50	0.9	7.7	4.00	3.4	118.50	117.50	0.3	Marsh & McLennan Cos Inc	NYSE	58.38	2.4	28.2	2.40	4.1	58.75	57.25	180.9
Employers Cas Co	OTC	34.50	0.0	7.9	-1.20	3.5	34.50	34.50	1.6	Poe & Assoc Inc	OTC	6.25	0.0	0.0	0.00	0.0	6.25	6.25	3.3
Equifax Inc	NYSE	34.63	4.9	13.9	1.70	4.9	34.63	32.50	33.4	Reed Stenhouse Cos Ltd	OTC	18.13	1.4	25.9	0.60	3.3	18.25*	17.88	237.7
Farmers Group Int	OTC	50.00	3.1	10.8	1.52	3.0	50.00	49.13	424.3	AGENTS/BROKERS				AVERAGE	26.8	2.5			
Foremost Corp Amer	OTC	27.00	-2.7	15.8	0.96	3.6	27.50	27.00	34.0	Conglomerates/Holding Cos.									
Fremont Gen Corp	OTC	17.88	7.5	25.5	0.48	2.7	17.88	16.88	188.3	American Express(Fireman's Fd)	NYSE	38.38	5.9	20.0	1.28	3.3	38.63*	37.00	8,878.1
Great West Life Assurn Co	OTC	325.00	0.0	8.7	12.00	3.7	325.00	325.00	0.0	Anderson Clayton(Ranger/PanAm)	NYSE	34.50	0.7	16.3	1.32	3.8	34.63	34.38	87.1
Hanover Ins Co	OTC	27.75	0.9	13.2	0.56	2.0	27.75	27.50	20.7	Ameco Inc	NYSE	10.75	7.5	0.0	0.00	0.0	10.75	10.38	626.7
Hartford Steam Boiler Inspnt	OTC	60.00	1.7	19.9	3.00	5.0	60.00*	59.50	7.6	CIGNA Corp	NYSE	45.63	4.6	37.7	2.60	5.7	45.63*	43.63	1,006.5
Jefferson Natl Life Ins Co	OTC	20.38	0.0	9.6	0.44	2.2	20.38	20.38	5.2	City Investing Co. (Home Ins.)	NYSE	39.50	0.3	9.5	2.00	5.1	39.75	39.00	806.5
Kemper Corp	OTC	44.13	-0.3	31.3	1.80	4.1	44.50	44.13	44.0	CNA Finl Corp (CNA)	NYSE	35.63	7.5	17.4	0.00	0.0	36.00*	33.13	102.5
Lincoln Natl Corp Ind	NYSE	40.00	6.0	9.3	1.84	4.6	40.00	37.75	487.9	Control Data (Comet. Credit)	NYSE	25.38	2.5	12.7	0.72	2.0	26.00	24.50	1,385.5
Mission Ins Group Inc	NYSE	8.50	-4.2	0.0	0.50	5.9	9.00	8.50	103.9	General Re Corp	NYSE	61.75	1.0	21.5	1.44	2.3	63.00	61.25	1,556.3
Northwestern Natl Life Ins	OTC	31.00	8.3	12.0	0.80	2.8	31.00*	29.25	689.1	ITT (Hartford Group)	NYSE	31.38	9.1	8.5	1.00	3.2	31.38	28.50	3,999.2
Ohio Cas Corp	OTC	46.00	0.0	17.5	2.68	5.8	46.13	45.88	68.2	Optimum Hldg Corp	OTC	0.13	0.0	0.0	0.00	0.0	0.13	0.13	1.0
Old Rep Intl Corp	OTC	30.00	-5.1	6.0	0.88	2.9	31.00	30.00	229.6	Sears Roebuck & Co. (Allstate)	NYSE	32.38	4.4	7.9	1.76	5.4	33.50	31.50	3,167.2
Orion Cap Corp	NYSE	21.00	-1.2	233.3	0.76	3.6	21.00	20.63	47.2	Teledyne Inc (Argonaut)	NYSE	239.00	2.7	13.1	0.00	0.0	239.88	231.75	360.7
Preferred Risk Life Ins Co	OTC	28.00	0.9	9.2	0.74	2.6	28.00*	27.88	8.6	Transamerica Corp	NYSE	26.75	0.0	11.1	1.64	6.1	26.88	26.25	476.6
Provident Life & Acc Ins Co	OTC	80.00	3.9	7.5	2.88	3.6	80.00	77.00	57.7	CONGLOMERATES/HOLDING COS.				AVERAGE	16.0	2.2			
St Paul Cos Inc	OTC	49.63	4.5	0.0	3.00	6.0	49.75	48.13	647.8										
SAFECO Corp	OTC	33.50	7.6	9.3	1.50	4.5	33.50	31.63	439.9										
Sri Corp	OTC	17.88	1.4	14.8	0.68	3.8	18.00	17.63	94.9										
Seibels Bruce Group Inc	OTC	20.00	3.9	0.0	0.80	4.0	20.00	19.25	39.5										
Statesman Group Inc	OTC	6.00	20.0	0.0	1.15	2.5	6.00	5.00	82.2										
Tokio Marine & Fire Ins Co	OTC	149.25	-2.3	25.8	1.05	0.7	152.00	149.25	13.5										
Travelers Corp	NYSE	38.00	3.1	9.6	2.04	5.4	38.13	37.00	1,118.4										
United Fire & Cas Co	OTC	20.00	21.2	0.0	0.80	4.0	20.00	17.00	2.7										

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