LICENSE COACH

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TYPES OF POLICIES

As you learn about the different types of life insurance, recall that life insurance protects against the risk of premature or untimely death. Keep in mind that your duties as an insurance producer involve helping clients select the appropriate types of coverage to fulfill their needs. Learn the distinguishing features of each policy.

Here is a general overview of different classes of insurance:

Types of Policies

Whole Life	Interest/Market-Sensitive	Term Life	Combination Plans
Ordinary (Straight) Life	Universal Life	Level	Joint Life
Limited-pay Life	Variable Whole Life	Decreasing	Survivorship Life (Second to Die)
Single-Premium Life	Variable Universal Life	Return of Premium	
Adjustable Life	Interest-sensative Whole Life	Annually Renewable	
	Equity-indexed Life	Increasing Term	

Group versus Individual

Individual	Group
Individual issued policy	Master policy issued for group
Individual selects plan	Group selects plans to pick from
Individual apply	Eligible employees apply
Individual underwriting	Group underwriting
More expensive	Less expensive
More restrictive	Less restrictive

- Group Life Insurance provides life insurance to many people under one policy. A master policy is issued to the organization, and individual certificates evidencing coverage are given to each member insured.
- Individual Life Insurance is issued on the life of one individual, with individual underwriting, rates, and coverage.

Permanent versus Term

- Permanent Life Insurance is whole life insurance that is effective for the entire life of the insured or up to age 100. Whole Life is permanent protection plus the cash value.

- Term Life Insurance is effective for a temporary period of time, designated by the policy. Term Insurance has no cash value and is temporary.

Participating versus Nonparticipating

- Participating Life Insurance policies are policies that pay dividends to policyholders, who have the option of receiving the dividend in cash, accumulate at interest, purchase more coverage, reduce premium prices, pay up the entire policy, or purchase 1-year term insurance. Mutual Insurance companies are participating.
- Nonparticipating Life Insurance policies are policies that pay dividends to shareholders, not policyholders. Stock Companies are nonparticipating.

Fixed versus Variable

- Fixed Life Insurance policies earn a constant rate of interest thereby providing a guaranteed minimum of benefits.
- Variable Life Insurance policies earn a fluctuating rate of interest and do not guarantee a certain cash value.

A. Traditional whole life products

Whole Life Insurance provides permanent life insurance protection for the insured's entire life, and living benefits including cash values and policy loans. Cash value in a whole life policy is a nonforfeiture value meaning that the policy owner is guaranteed to it. Policies are issued based on the insured's original, or issue age (age at application).

1. **Ordinary (straight) life**
   Ordinary, or straight life, is basic whole life insurance with a level face amount, and level premiums payable over the insured's entire life.

2. **Limited-pay and single-premium life**
   Limited Payment (LP) Whole Life Policies: The insured is covered for his entire life, but premiums are paid for a limited time. Face amount and premiums are level.
   Single Premium Whole Life Policy: It allows the insured to pay the entire premium in one lump-sum, and have coverage for the insured's entire life. Policies have a level face amount.

3. **Adjustable life**
   Adjustable Life policies are a mix of whole and term life insurance. Changes that can be made to the policy: raise or lower premium, raise or lower the face amount, change the coverage period, and change the premium-paying period.

Traditional Whole Life

	Death Benefits	Premiums	Cash Value
Ordinary (Straight) Life	Level Face Amount	Level premiums payable over the insured's entire life	Cash value is a nonforfeiture value and is guaranteed.
Limited-pay		Level premiums	

		paid for a limited time	
Single-premium Life		Premium paid in one lump-sum	
Adjustable Life	Face amount can be adjusted	Premiums can be raised or lowered	

B. Interest/market-sensitive life products

Variable insurance provides a way for policyowners to earn higher investment returns on life insurance policy cash values. With traditional whole life insurance, premiums are invested in the insurer's general account, which contains conservative investments carefully selected and insured by the insurance company. Interest rates provided by the general account are fixed and conservative, in the 3% – 5% range.

With variable life insurance, on the other hand, policyowners have the opportunity to earn higher interest rates. The interest rate is variable because it is linked to the insurer's separate account, which fluctuates according to its investment performance. Since the separate account is not insured by the insurance company, the investment risk is borne upon the policyowner.

Variable life insurance products are securities contracts and are regulated by the Securities and Exchange Commission (SEC). Agents selling variable products must have a life insurance and a FINRA representative license.

1. **Universal life**
   Universal Life is also referred to as flexible premium adjustable life insurance or unbundled insurance. The primary difference between adjustable life and universal life is that the policy owner can skip premium payments as long as there is enough cash value in the policy to cover the cost of death protection. Policy allows the policy owner to "buy term and invest the difference." Two premiums are quoted to the policy owner: the target premium and the minimum premium. Paying the target premium will build cash value in the policy, and the policy will resemble whole life. Paying the minimum premium will keep the policy in force by paying the cost of death protection, and the policy will resemble term life.

   There are two death benefit options for universal life policy owners:
   1. Option A (Option 1): pays a level death benefit.
   2. Option B (Option 2): pays an increasing death benefit: face amount and cash value.

2. **Variable whole life**
   Variable whole life or simply variable life has fixed level premiums and a guaranteed minimum death benefit just like ordinary whole life but differs in that it offers higher interest rates defending the policy owner against the effects of inflation.

   - Only variable life policies allow policy owners to invest premiums in the insurer's separate account.
   - Variable life insurance policies do not guarantee cash value.

- Any agent selling variable products must have a securities license in addition to a life insurance license.
- Variable policies have fixed premiums and a guaranteed minimum death benefit.
- The investments are in a Separate Account.
- Producers must be registered with FINRA.

3. Variable universal life

It is universal life insurance with a separate account. These policies have the flexible features of universal life and the investment choices of variable life. Variable universal life policies are regulated as variable products. Features include:

- Flexible premiums,
- Cash value based on investment in separate account,
- Access to cash values (policy loans and withdrawals),
- Death protection deducted from cash value,
- Death benefit option A or B; and
- Policy owners choose sub-account investments.

4. Interest-sensitive whole life

Interest-sensitive whole life, also known as current assumption whole life, provides flexible (varying) premiums based on a changing current interest rate.

- The insurer may raise or lower the premium within a specified range stated in the policy.
- Higher interest rates allow the insurer to reduce the premium, and lower interest rates require the insurer to raise the premium.
- If the insured does not want to pay higher premiums, the policy face amount can be reduced.
- Premium changes usually occur annually.

5. Equity-indexed Universal life

Equity indexed universal life works the same way as universal life insurance, except the interest rate is tied to the stock market index, which has the potential to offer greater cash value growth than universal life insurance.

Equity indexed universal life policies have a fixed guaranteed interest rate and a nonguaranteed indexed rate which can reach yields of 15% – 20% or more. This allows policyowners to reap the benefits of indirectly participating in the stock index. Typically, insurers use the S&P 500 Index.

Interest/ Market Sensitive

	Death Benefits	Premiums	Cash Value
Universal Life	Option A: level death benefit; OR Option B: increasing death benefit	Pay the target premium to build cash value; OR Pay the minimum premium to cover	Any cash value above the cost of insurance is guaranteed

		the cost of death protection	
Variable Whole Life	Guaranteed minimum death benefit	Fixed level premiums that can be invested in insurer's separate account	Cash value NOT guaranteed; Higher interest rates defend against inflation
Variable Universal Life	Option A: level death benefit; OR Option B: increasing death benefit	Flexible premiums that can be invested in insurer's separate account	Cash value is based on investment and NOT guaranteed
Interest-sensitive Life	Policy face amount can be reduced to offset paying increased premiums.	Flexible changing premiums based on current interest rates	Any cash value above the cost of insurance is guaranteed
Equity-indexed Life	Option A: level death benefit; OR Option B: increasing death benefit	Flexible premiums with interest tied to stock market index.	Cash value from a fixed guaranteed interest rate plus the option of a nonguaranteed indexed rate for larger return.

C. Term life

Term life insurance provides pure death protection since it only pays a death benefit if the insured dies during the policy term. Term life insurance does not accrue cash value.

1. Types

Level Term: Level policies provide a level face amount throughout the policy period. Two types: annual renewable term and level premium term.

Decreasing Term: Policies that provide a face amount that decreases to zero over the policy period. The face amount equals zero on the day the policy expires. The premiums are level. E.g. mortgage reduction insurance.

Return of premium: A new kind of policy is called the return of premium (ROP) term policy. ROP term policy premiums are generally higher than a conventional term policy. The longer the term, the lower the premium. Premiums are returned to the insured if no death benefit has been paid and are not taxable.

Annually renewable: A type of level term policy that has a level face amount and increasing premiums.

Increasing term: Insurance that provides an increasing face amount with level premiums.

2. Special features

Renewable Term Policies: Policies that allow the policy owner to renew the term policy after the designated term expires without having to prove insurability.

Convertible Term Policies: Policies that allow term life policy owners to convert their term insurance into permanent policies without showing proof of insurability. Upon conversion, a convertible term policy will have higher premiums because permanent protection is more expensive than term protection.
Original Age–The original age is the insured's age upon conversion.
Attained Age– The attained age is the insured's age upon purchase of the term policy.

D. Annuities

While life insurance protects against the risk of premature death, annuities protect against the risk of living too long. The risk involved with living too long is depleting financial resources and savings.

At its most basic, an annuity provides guaranteed income for life by systematically liquidating an estate. Two of the most common uses of annuities are providing lifetime income and accumulating money for a retirement fund.

1. Single and flexible premium

Single Premium
Annuities may be funded with a single lump sum premium. This immediately creates a principal sum. Annuities funded with a single premium are either:

- Single Premium Immediate Annuity (SPIA): A lump sum payment is made with the insurer, and payments to the annuitant start immediately; or
- Single Premium Deferred Annuity (SPDA): A lump sum payment is made to the insurer, and the payments to the annuitant are deferred until a specified time. The monies deposited grow tax-deferred until annuitization.

Flexible Premium

A flexible premium arrangement is similar to a level premium annuity, except that the owner of the annuity can elect to pay varying amounts for each premium payment.

- The amount of each premium payment must fall within a certain minimum and maximum amount.
- An annuity where both the premium amount and frequency of premium payments are flexible is called a *flexible premium deferred annuity* (FPDA).
- Flexible premium annuities are appropriate for individuals who have fluctuating incomes, or who are unable to pay for an annuity in one lump sum.
- The major drawback of flexible premium annuities is the inability to determine the actual amount of the annuity benefit.
- Because the amount of each premium payment to be paid and the total

amount that will be paid into the annuity is a flexible amount that depends on future premium payments, there is no way to determine the exact amount of the annuity benefit that will be received until the final premium payment is received.

2. Immediate and deferred

Annuities can be broadly categorized into two types: immediate and deferred. These two types refer to when the annuity phase (payout period) begins.

- Immediate Annuities are annuity payments that begin immediately after the annuity is purchased, do not have an accumulation period, and have payout periods which must begin within one year of the first premium payment.
- Deferred Annuities have annuity periods beginning sometime in the future, after one year from purchase, or later. It can be purchased with one or multiple premium payments.

3. Fixed and variable

Fixed Annuities

Fixed Annuities have a guaranteed minimum interest rate at which the premium payments accrue interest during the accumulation phase and a fixed interest rate at which level annuity payments are paid during the annuity phase. Premiums for a fixed annuity are invested in the insurer's general account. Fixed annuities pay a level annuity payment throughout the annuity phase.

Variable Annuities

Variable Annuities have variable interest rates and benefits, and the insurer cannot guarantee a certain dollar amount periodic annuity benefit. Policy owners choose where their premiums are to be invested. Premiums can be invested in the insurer's general account and/or separate account.

The separate account is specifically used for variable investments. Variable annuities are considered securities products, and as such must be registered with, and are regulated by the SEC. Producers selling variable products must have a securities license in addition to a life insurance producer license.

- Accumulation Units: When a contract owner pays premiums into the separate account, he is purchasing accumulation units. The separate account has a certain total number of accumulation units. The value of each accumulation unit can be calculated by dividing the value in the separate account by the insurer's total number of accumulation units. The number of accumulation units a contract owner has directly correlates to what portion of the separate account the contract owner owns.
- Annuity Units: During the annuity phase, annuity units are used in lieu of accumulation units to determine the amount of each annuity payment. The number of annuity units is fixed and is based on the contract's dollar value investment in the separate account, and how much the first annuity payment will be.

4. Indexed

Equity Indexed Annuities are fixed annuities that provide a guaranteed minimum interest rate.

E. Combination plans and variations

1. Joint life

Joint life insurance policies insure the lives of two or more people. Premiums for joint life policies are less expensive than if each life was insured on a separate policy.

First-to-die Joint Life: Policy that pays the face amount upon the first insured's death. After the first insured dies, the contract does not provide any further life insurance coverage.

2. Survivorship life (second to die)

Survivorship Life: A type of joint life policy where policy proceeds are only paid out upon the death of the second insured.

POLICY RIDERS, PROVISIONS, OPTIONS, AND EXCLUSIONS

In life insurance, there are no "standard" policies; however, states have made an effort to standardize provisions recommended by the NAIC. Life insurance provisions, options, and riders make each life insurance policy unique. ***Provisions*** are the characteristics, privileges, duties of all parties, and rights of a policy. ***Options*** involve how policy funds are utilized. ***Riders*** are policy elements that "ride on" or add to the existing coverage by modifying provisions or coverage.

The following chart provides a summary of the various policy provisions, options, and riders.

Policy Provisions, Options and Riders

Provisions	Options	Riders
Rights (Protect Policy Owner)	*Choices on How to Distribute a Sum of Money*	*Add or Modify Coverage (Customize)*
Rights of Ownership	*Divided Options*	*Guaranteed Insurability Rider*
Standard Provisions	*Nonforfeiture Options*	*Waiver of Premium Rider*
Entire Contract	*Settlement Options*	*Automatic Premium Loan*
Insuring Clause		*Payor Provisions Rider*
Free-Look		*Accidental Death Benefit*
Consideration		*Return of Premium Rider*
Grace Period		*Cost of Living*
Reinstatement		*Other Insureds Rider*
Policy Loan		
Incontestable		
Assignment		
Accelerated Benefits		
Suicide Provisions		
Misstatement of Age/Sex		
Automatic Premium Loan		

A. Policy riders

Another name for policy riders is policy add-ons. Life insurance policies can be customized by adding policy riders or endorsements to meet the specific needs of a client. While a policy rider adds additional benefits to a life insurance policy, it also usually raises the premium amount.

1. Waiver of premium rider: Allows the policyowner to waive premium payments during a disability, and keeps the policy in force. The disability must be total and permanent. After a certain age (usually 60 or 65), the waiver of premium rider is void.

2. Guaranteed insurability: Permits the policyowner to buy additional permanent life insurance coverage at specific points in time in the future (i.e. marriage, births, etc.) without requiring the insured to provide proof of insurability.

3. Payor benefit: If the individual paying the premiums on a juvenile life policy becomes disabled or dies before the insured child reaches a certain age, such as 21, the policy premiums will be waived until the child reaches the specified age.

4. Accidental death and/or accidental death and dismemberment: May be added to a life insurance policy. Pays benefits for dismemberment and accidental death. Pays a principal sum for loss of both hands, both arms, both legs, or loss of vision in both eyes.

5. Term riders: Adds term coverage to an existing life insurance policy.

6. Other insureds (e.g., spouse, children, nonfamily): Riders can be attached to protect the insured's spouse, children, or both.

7. Long term care: A type of accelerated benefit, which is used to pay long-term care costs.

8. Return of premium: Rider pays the total amount of premiums paid into the policy as long as the insured dies within a certain time period specified in the policy.

B. Policy provisions and options

Policy provisions are conditions or clauses that identify the rights and obligations of the parties in a contract. In other words, policy provisions are the rules which direct how the two parties must plan the game of Life Insurance.

1. Entire contract: The insurance policy itself (including any riders and endorsements/amendments) and the application, if attached to the policy, comprise the entire contract between all parties. Insurance producers cannot make changes to a policy. Only an authorized officer of the insurer is permitted to make changes to the contract.

2. Insuring clause: The insurer's basic promise to pay benefits in the event of a covered loss.

3. Free look: The policyowner is permitted a number of days from the date the policy is delivered (usually 10) to look over the policy and return it, if dissatisfied for any reason, for a refund of all premiums paid.

4. Consideration: A policyowner must pay a premium in exchange for the insurer's promise to pay benefits.

5. Owner's rights: The ownership provision stipulates the rights of the policyowner.

6. Beneficiary designations

a. Primary and contingent: The policyowner may name up to three levels of prioritized beneficiaries: primary, contingent and tertiary. The beneficiaries at lower levels of priority (contingent and tertiary) do not receive policy proceeds unless the higher level(s) beneficiaries predecease the insured.

b. Revocable and irrevocable: The policyowner can change revocable beneficiaries without their consent. However, with irrevocable beneficiaries, the policyowner must receive their written consent to exercise any ownership rights except for the right to pay premiums.

c. Changes: The policyowner can change beneficiaries at any time without their consent as long as they are named as revocable. The policyowner must receive the irrevocable beneficiary's written consent

to change a beneficiary. The policyowner may request a change to the named beneficiary either:

- By filing (contacting the insurer via phone or in writing and requesting the change – the *recording method*); or
- By an endorsement (changing the policy itself to indicate the change in beneficiary).

It is important to note that the changing of a designated beneficiary cannot be done through a will. In addition to a change in revocable beneficiary, the owner of a life insurance policy also has the power to make a policy loan or surrender the policy for its cash value, without the beneficiary's consent. However, the policyowner may not increase the amount of the insurance without the beneficiary's consent.

d. Common disaster: It protects contingent beneficiaries' rights by stipulating a certain number of days the primary beneficiary must outlive the insured after a common accident causing near-simultaneous death in order for the primary beneficiary to receive the policy proceeds; otherwise, the contingent beneficiaries receive the policy proceeds. If the primary beneficiary dies before the insured, then the policy proceeds are paid to the contingent beneficiaries, or if none, to the insured's estate. If the insured dies before the primary beneficiary, then the policy proceeds are paid to the primary beneficiary only if he outlives the insured by the specified number of days. The stipulated period is usually 15 or 30 days.

e. Minor beneficiaries: A minor can be named as a beneficiary, but because a minor cannot legally receive policy proceeds, a guardian or trustee must be appointed who can legally receive the policy proceeds and manage them until the minor reaches the legal age. A trust can be established if a guardian cannot be relied upon to manage the funds. Insurance companies may make restricted life payments to an adult guardian on behalf of the minor beneficiary. The insurer may also keep the policy proceeds to accrue interest until they may be paid to the minor when he or she reaches the age of majority or when an adult guardian has been appointed. Finally, the insurer may put the policy proceeds in a trust on behalf of the minor.

7. Premium Payment

a. Modes: The premium payment mode is the frequency that premium payments are made. Most insurers accept premium payments annually, semi-annually, quarterly, and monthly. Home service policies accept weekly premiums.

b. Grace period: The stipulated period of time policyowners are allotted to pay an overdue premium during which the policy remains in force.

c. Automatic premium loan: Allows the insurer to automatically use the policy cash value to pay an overdue premium.

d. Level or flexible: Life insurance premium payments can be level or flexible. Level premiums remain constant, while flexible premiums can vary in amount or frequency.

8. Reinstatement: Permits the policyowner to reinstate a policy that has lapsed, as long as the policyowner can provide proof of insurability.

9. Policy loans, withdrawals, partial surrenders: Policies that permit cash value have policy loan and withdrawal provisions. These policies must begin to build cash value after a certain number of years. In most states, this is 3 years. The policyowner has the right to the policy's cash value. Policy loans are not taxable.

- **Cash Loan**: Policyowners can make a policy loan in an amount up to the current cash value, less any existing indebtedness (prior loans with interest).
- **Automatic Premium Loans**: Allows the insurer to automatically use the policy cash value to pay an overdue premium.
- **Withdrawals or Partial Surrenders**: Withdrawals or partial surrenders of policy cash value can be made from universal life policies.
- **Modifications:** Policy changes must be made by an authorized officer of the insurer and attached to the policy. Only the policyowner has the right to request changes.
- **Medical Examination and Autopsy**: Require the proposed insured to undergo a medical examination prior to issuing coverage at the insurer's expense if necessary, such as for large amounts of coverage. Provision grants right of autopsy to insurer, at the insurer's expense.
- **Excess interest provision**: When a life insurance policy's interest rate becomes greater than the assumed interest rate, the policy will build excess cash value.

10. Non-forfeiture options: Nonforfeiture options/values are guarantees that are required by law to be part of life insurance policies that build cash value. Insurers are required to make nonforfeiture values available when policyowners discontinue premium payments for any reason.

- **Cash Surrender Value**: Allows the policyowner to receive the policy's cash value.
- **Extended Term Option:** Permits the policyowner to use the policy's cash values to buy paid-up term insurance.
- **Reduced Paid-up Insurance Option:** Allows the policyowner to purchase paid-up whole life coverage at a reduced face amount based on the amount of the policy cash value. No more premium payments are made.

11. Dividends and dividend options: Though not guaranteed, participating policies pay dividends to policyowners. Recall that dividends are a return of overcharged premium, and are therefore not taxable. Insurers typically pay dividends on an annual basis. Dividend options are the choices available to policyowners for settling dividend payment.

- **Cash Payment Option**: The policyowner receives a check for the amount of the dividend.
- **Reduction of Premium Payments Optio**n: Allows the policyowner to use the dividend to offset the cost of a future premium payment.
- **Accumulation at Interest Option:** Allows the insurer to retain the dividend to be invested and grow in value.
- **One-year Term Option:** Allows the policyowner to use the dividend as a single premium to purchase one-year term protection

- **Paid-up Additions Option:** Allows the policyowner to use the dividend as a single premium to purchase an additional amount of whole life coverage.
- **Paid-up Insurance Option:** Allows the policyowner to use dividends to pay up the policy earlier.

12. Incontestability: Prevents the insurer from denying a claim or voiding a life insurance policy, except for nonpayment of premiums, after the policy has been in force for a certain number of years, usually 2.

13. Assignments: The right to transfer policy rights to another person or entity. An absolute or complete assignment occurs when the policyowner assigns all rights including cash values to another person or entity.

14. Suicide: The policy will be voided and no death benefit will be paid if the insured commits suicide within a stipulated time period, usually 1 or 2 years from policy issuance.

15. Misstatement of age and gender: Allows the insurer to adjust the policy benefits if the insured's age or sex is misstated on the policy application.

16. Settlement options: Settlement options are the ways that life insurance policy proceeds are paid out to beneficiaries upon the insured's death or when the policy endows. Settlement options allow the policy proceeds to be retained by the insurer and paid out gradually.

- **Lump-Sum:** One cash payment.
- **Interest Only**: The insurer retains the policy proceeds, which become the principal, and pays out only the growth on the principal to the beneficiary on a scheduled basis.
- **Fixed-period** or **Period Certain**: Installment option that uses an annuity to pay the policy proceeds to the beneficiary for a certain number of years.
- **Fixed-amount Installment Option:** Uses an annuity to pay the policy proceeds, but the payment amount is specified instead of period of time.
- **Life Income:** Option that uses an annuity to pay the policy proceeds. The beneficiary is provided with income that cannot be outlived: income is guaranteed for the beneficiary's entire life.
- **Straight Life** or **Single Life**: Pays the beneficiary periodic income for his entire life. Once the beneficiary dies, the payments stop, and any balance of principal is forfeited to the insurer.
- **Refund Life Option:** Pays the beneficiary periodic income for his entire life. If the beneficiary dies before the policy proceeds have been paid out entirely, then a second beneficiary receives the payments until the principal reaches zero. The refund life option provides a guarantee that the minimum benefit will be paid out.
- **Life Income Certain Option:** Pays periodic payments to a beneficiary for his entire life. If the beneficiary dies before a specified period in the policy has passed (such as 10 or 15 years), then a second beneficiary will receive payments until that period ends. The life income certain option provides the beneficiary with a guarantee that benefits will be paid for a minimum number of years.
- **Joint and Survivor Option:** Allows two or more individuals to receive income payments for their entire lives.

Settlement Options	
Cash Payment (Lump Sum)	*Not taxable to beneficiary*
Life Income	*Pays a guaranteed installment as long as the recipient lives. Principle is forfeited upon death*
Interest Only	*Temporary option until proceeds are paid out using one of the other settlement options*
Fixed-period Installments	*Depletes funds over a fixed period* *Example: $100,000* *10 years = $10,000/year* *20 years = $5,000/year*
Fixed-amount Installments	*Pays fixed amount until proceeds are exhausted* *Example: $100,000* *$5,000/year = 20 years* *$10,000/year = 10 years* *$20,000/year = 5 years*

17. Accelerated death benefits: Allows the insured to receive a portion of the death benefit prior to death if the insured has a terminal illness.

Here is a summary chart of policy options:

Dividend Options	Nonforfeiture Options	Settlement Options
Cash Payments	Reduced Paid-up	Cash Payment
Reduction of Premiums	Extended Term	Life Income
Accumulation at Interest	Cash Surrender Value	Interest Only
Paid-up Additions		Fixed-period Installments
One-Year Term		Fixed-amount Installments

C. Policy exclusions

The policy exclusions section of the contract states what the insurer will not do, including the risks that the insurer will not cover. Policy exclusions are optional, and may be included in life insurance policies at the discretion of the insurer.
These provisions exclude or limit coverage and are intended to protect the insurer

from adverse selection and misuse of policies.

Suicide Clause: The policy will be voided and no death benefit will be paid if the insured commits suicide within a stipulated time period, usually 1 or 2 years from policy issuance.

Aviation: The insurer will not pay the claim if the insured dies due to involvement with aviation, such as a military pilot flying a jet aircraft.

War or Military Service: The insurer will not pay the claim if the insured dies while in active military service or due to an act of war.

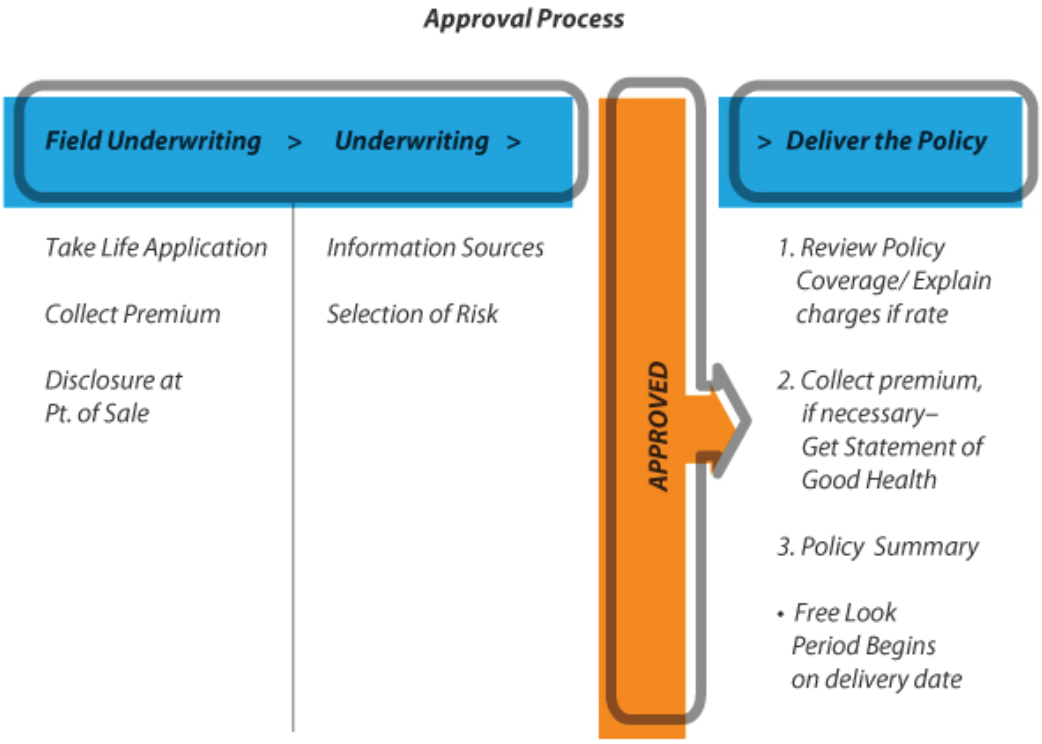
Status clause – the insurer will not pay the claim if the insured dies while in active military service.

Results clause – the insurer will not pay the claim if the insured dies due to an act of war.

Hazardous Occupation or Hobby: If the insured dies as a result of a hazardous occupation or hobby, the insurer will not pay the claim.

COMPLETING THE APPLICATION, UNDERWRITING, AND DELIVERING THE POLICY

In this section we will cover the process involved with applying, issuing, and delivering insurance policies. The first step is completing the application. Next, the underwriting process helps determine the classification of risks and rates of the policy. And finally, we will look at the delivery of the policy.



A. Completing the application

The application is one of the primary sources of information used in underwriting an insurance policy. The person who applies for coverage must complete and submit the application. In most cases, the application is attached to, and becomes part of the contract. The application is attached to the policy so that it becomes a legal part of the insurance contract. Therefore, if the insurer discovers intentional misstatements in the application, the application can be used as a legal document.

1. Required signatures
The agent and the applicant are required to sign the application. If the applicant is someone other than the proposed insured, except for a minor child, the proposed insured must also sign the application (in some states once a minor reaches the age of 15, the minor is eligible to contract for a life or health insurance policy). It is important for the agent to be present to witness any and all signatures. Disclosure forms and additional questionnaires that the applicant must complete must be signed by both the agent and the applicant. If automatic checking account drafts will be used for premium payment, the applicant must sign agreeing to such.

2. Changes in the application
If an agent notices a minor error on the application, the producer should correct the information in the presence of the applicant and have the applicant initial the change. Changes should be struck through, not erased. If the agent notices a major error on the application, the agent should start a new application for the prospective insured and safely dispose of the previous

application.

3. Consequences of incomplete applications
If an agent notices that the application is incomplete, the agent should have the applicant fill in the incomplete sections and then submit the application to the insurer. If the insurer approves an incomplete application, then the insurer has waived its right and is legally estopped from reasserting the right.

4. Warranties and representations
Warranties are statements that are guaranteed to be true and are part of the legal contract. Breach of warranty is grounds for voiding an insurance contract. Representations are statements made by the insured, to the best of his knowledge.

5. Collecting the initial premium and issuing the receipt
Producers should make every effort to collect the initial premium with the application. The producer issues the applicant a premium receipt upon collecting the initial premium.

6. Replacement
Part 1 of the application includes information about existing policies if the proposed coverage is intended to replace existing coverage. If the agent discovers that the proposed coverage is replacing existing coverage, the policy is considered a replacement, meaning that the agent must comply with certain regulations regarding replacement.

7. Disclosures at point of sale (e.g., HIPAA, HIV consent)
Insurers are also permitted to request applicants undergo an HIV test as part of the application requirements, at the insurer's expense. Insureds must sign a consent form before the HIV test may be performed. Disclosures of privacy regulations must also be given to the applicant.

8. USA PATRIOT Act/anti-money laundering
The USA PATRIOT Act (Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001) gives more leeway to law enforcement agencies in searching the following records: email & telephone communications, medical, financial and foreign intelligence garnered within the U.S. The Act provides a means for preventing, detecting and prosecuting international money laundering (money laundering is concealing the origin of money – money that has been obtained illegally, such as through crimes, drug trafficking, etc.), especially money which is used to finance terrorism. The Act institutes more stringent record-keeping rules for financial institutions, such as requiring thorough records for transactions processed from parts of the world in which laundering is particularly a concern.

B. Underwriting

Underwriting is the process that insurance companies use to select, classify and rate risks. Insurance companies use the underwriting process to prevent adverse selection, which could cause the insurance company to become insolvent. Underwriting is used to classify risks and assign premium rates that accurately reflect the amount of risk undertaken by the insurance company. While the selection, rating, and classifying of risks are part of the underwriting process, the notification of risks is NOT part of the underwriting process.

1. Insurable interest
For life insurance, insurable interest exists when the applicant financially prospers from the continued life of the insured, and the death of the insured would cause financial hardship. Insurable interest must be present when the policy is applied for; however, insurable interest does not need to exist thereafter. In either case, the death benefit will be paid.

There are three categories of insurable interest in life insurance:

- A person's own life
- The lives of relatives or spouses
- In business/financial relationships

2. Medical information and consumer reports
The Medical Information Bureau is a nonprofit trade organization which maintains medical information about individuals. Information from the MIB is used by life and health insurers. Member insurers supply the MIB with confidential aversive information about an applicant for insurability purposes. Information collected includes underwriting information such as an individual's hazardous activities and impairments to insurability; however, the MIB does not collect claims information or how much coverage an individual has. Insurers may access MIB information on an applicant only if needed for additional investigation. Insurers cannot refuse to issue policies solely on information supplied by the MIB.

Consumer Reports are any written, oral, or other communication of information by a consumer reporting agency about a consumer's credit worthiness, character, general reputation, personal characteristics or mode of living which are used to determine a consumer's eligibility for credit, insurance, employment, or other authorized purposes. The person seeking a consumer report on an individual must have a valid business need for the information.

Investigative Consumer Reports contain information on a consumer's character, general reputation, personal characteristics, or mode of living, but are obtained through personal interviews with neighbors, friends, or associates of the consumer. Investigative consumer reports cannot be performed unless the consumer has been notified in writing of the report within three days of when the report was initially requested.

3. Fair Credit Reporting Act

The Fair Credit Reporting Act (FCRA) was passed in 1970 with the purpose of regulating the way credit information is collected and used. The Act requires consumer reporting agencies to implement policies and procedures to preserve the confidentiality, accuracy, relevance, and appropriate utilization of consumer's private credit information. There are two types of reports insurance underwriters will utilize to obtain credit information about an applicant:

- Consumer Reports and
- Investigative Consumer Reports.

Consumers must be informed that they have the right to request additional information about the report; such information must be provided to consumers within five days, if requested. Consumers must be informed at the time of application that a consumer report may be requested, regardless of whether a report is actually ordered or not. Consumers should also be informed that they have the right to request additional information about the report, such as the name of the company that provided them with a report.

4. Risk classification
Underwriters use the following rating classification system to categorize the favorability of a given risk: preferred, standard, substandard, and declined.

- **Preferred:** Individuals who are above average in terms of physical condition and lifestyle and present a less than average risk to the insurer.
- **Standard:** Individuals in average physical condition with average lifestyles and habits.
- **Substandard:** Higher risks, due to the applicant's physical condition, disease history, hazardous occupation or dangerous hobbies or habits.
- **Declined:** Risks that are uninsurable because the applicant is too risky for an insurer to provide coverage.

5. Stranger-originated life insurance (STOLI)
In Stranger-originated Life Insurance, or STOLI, a consumer purchases a life insurance policy with the agreement that a third party agent/broker or investor will purchase the consumer's policy and receive the proceeds as a profit upon the consumer's death. The stranger may purchase the policy, naming themself as beneficiary, or use it for resale to an investor. Upon the insured's death, the stranger or investor receives the policy proceeds. The insured receives some sort of small financial benefit in this arrangement.

Under STOLI arrangements, the insured is usually a person who is either elderly (typically ages 65 to 85) or terminally ill. STOLI arrangements are used to make a profit on these individuals who are near death. In a sense, it is gambling on a person's life because the stranger or investor is betting the insured will die before they pay out a lot of money in premiums.

6. Investor-originated life insurance (IOLI)
Investor-originated life insurance (IOLI) is a type of STOLI. With IOLI, investors solicit elderly people to purchase life insurance, and an agent or broker agrees to loan insureds money to pay the premiums for a period of time, with the agreement that after two years of paying premiums the investors become the policyowners, and receive the policy death benefits upon the insured's death. Investors supply funds to a "pool" of STOLI-type policies with the expectation that the insureds die very soon, so that they earn a profit on the death benefit.

In most cases, the lender is the investor, who uses the STOLI policy as collateral on the loan. If the insured dies during the 2-year loan period, the investor/stranger repays the loan and then receives the death benefit. If the insured is alive after the 2-year loan period, the policy is sold to investors in an amount that is greater than the policy's cash value, but less than its death

benefit. In exchange, the insured receives a nominal lumpsum payment for essentially facilitating a third party's profit upon their upcoming death.

STOLI and IOLI are ethical dilemmas because the investor or stranger does not have insurable interest in the *continued life and wellbeing of the insured*. They want the insured to die very soon, so that they will receive the policy death benefits. Often times, once the policy has been sold to a stranger/investor, the insured will be contacted several times a year to see if he/she has died.

C. Delivering the policy

1. When coverage begins

A policy is delivered after the insurer approves the application and issues the policy for delivery. The policy does not take effect until the initial premium has been collected, the application approved, and the policy is issued and delivered. Some insurers require a Statement of Good Health to be signed and collected from the insured, verifying that the insured has not become ill, injured, or disabled during the policy approval process.

The effective date of coverage is the date the policy coverage becomes effective and in force. The effective date of coverage is the date of the application as long as the premium accompanies the application, and the policy is approved as applied for. Otherwise, the effective date of coverage is the date the policy is delivered, the statement of good health signed (if required) and the premium collected.

2. Explaining the policy and its provisions, riders, exclusions, and ratings to the client

The applicant must receive a document explaining the coverage purchased and the names of the insurer and agent. In life insurance, this document is called the policy summary.

TAXES, RETIREMENT, AND OTHER INSURANCE CONCEPTS

A. Third-party ownership

In third-party ownership the three parties to the contract are the policyowner, insured and insurer. The policyowner must have an insurable interest in the life of the insured.

B. Group life insurance

Businesses, as well as individuals, buy life insurance for financial protection. Businesses purchase life insurance policies and annuities for a variety of reasons. One type of life insurance purchased by businesses is Group Life that is offered to employees to protect their family members and beneficiaries

Group life is differentiated from individual life in that enrollees typically:

- Do not have to provide evidence of insurability,
- Are not issued individual policies
- Do not own the contract.

1. Conversion privilege

Conversion to Individual Policy: If a member's coverage is terminated, the

member and his dependents may convert their group coverage to individual whole life coverage, without having to show proof of insurability.

Conversion Period: An individual must apply for individual coverage within 31 days after the date of group coverage termination. An individual is covered under the group policy during the conversion period.

Group Policy Termination: If the master policy is terminated, each individual member who has been insured for at least 5 years is permitted to convert to an individual policy, providing coverage equal to the face value of the group policy.

2. Contributory vs. noncontributory
Group insurance premiums may be paid in two ways:

- **Contributory:** Contributory is where the premiums are paid jointly by the policyowner and insured. Contributory plans require **75%** participation of the group's eligible employees.
- **Noncontributory:** Noncontributory is where the premiums are paid entirely by the policyholder. Noncontributory plans require **100%** of the group's eligible employees to participate.

C. Retirement plans

Retirement plans are tools that help people save money for their non-working years. Retirement plans are important to employers because they attract good employees and help employees remain financially stable in retirement. However, one non-tax advantage to retirement plans for employees, but not for employers, is forced savings.

1. Tax-qualified plans
Qualified plans are retirement plans for the exclusive benefit of employees and beneficiaries. Qualified plans provide tax benefits and must be approved by the IRS. The plans must be permanent, in writing, communicated to employees, defined contributions or benefits, and cannot favor highly paid employees, executives, or stockholders. The primary type of qualified plans includes defined benefit and defined contribution plans.

Qualified plans have the following features:

- Employer's contributions are tax-deductible as a business expense.
- Employee contributions are made with pretax dollars – contributions are not taxed until withdrawn.
- Interest earned on contributions is tax-deferred until withdrawn upon retirement

Tax Benefits of Qualified Plans

Employer's contributions are tax-deductible and not treated as taxable income to the employee. Employee contributions are made with pre-tax dollars, and any interest earned on both employer and employee contributions are tax-deferred. Employees only pay taxes on amounts at the time of withdrawal.

Withdrawals and Taxation

Withdrawals by the employee are treated as taxable income. Withdrawals by the employee made prior to age **59** ½ are assessed an additional 10% penalty tax. Withdrawals are mandatory at age **70** ½, and failure to take the required withdrawal results in a 50% tax on those funds.

Funds may be withdrawn prior to the employee reaching age 59 ½ without the 10% penalty tax, if the employee dies or becomes disabled, a loan is taken on the plan's proceeds, the withdrawal is the result of a divorce proceeding, the withdrawal is made to a qualified rollover plan, or the employee elects to receive annual level payments for the remainder of his life.

2. Nonqualified plans

Nonqualified plans are used just as frequently as qualified plans, despite the fact that they do not have the tax advantages of qualified plans. Nonqualified plans permit employers to offer retirement plans only to their key employees. Common nonqualified plans for retirement include:

- split dollar plans,
- deferred compensation, and
- executive bonus plans.

There are numerous other types of nonqualified plans – such as a personal savings account or an individual deferred annuity. Nonqualified plans are characterized by the following:

- Do not need to be approved by the IRS
- Can discriminate in favor of certain employees
- Contributions are not tax-deductible
- Interest earned on contributions is tax-deferred until withdrawn upon retirement

D. Life insurance needs analysis/suitability

1. Personal insurance needs

Survivor Protection-One of the most common reasons for purchasing life insurance is to provide financial protection for family and dependents if the insured dies. The death of either spouse can strain the financial stability of a family. Life insurance can provide a family with a stream of income to fulfill the family's basic necessities of life and current lifestyle. These needs include: mortgage payments, living expenses, children's education, health insurance, and surviving spouse's retirement income.

Estate Creation-Life insurance creates an immediate estate. Estates may be created in other ways, such as through savings and investments, but if such methods are not effective or time does not permit, life insurance can assume the role of estate creation. For example, an investment fund may take years to grow; whereas, a life insurance policy purchased today creates an immediate estate in a minimum amount of at least the initial premium.

Cash Accumulation-Life insurance policies that build cash value (whole life policies) may be used as a cash accumulation vehicle for any number of purposes. A life insurance policy that builds cash value is said to have living benefits. Some common purposes for accumulating cash include funding a

college education, saving for retirement, or purchasing a home.

2. Business insurance needs
Buy-Sell Funding is life insurance funded agreements used to assure that the ownership of the business is sold to the surviving owners in the event of the insured employee's death or disability.

Key Person Insurance is Insurance purchased to prevent the financial loss that may ensue when an owner, officer or manager dies. The company purchases, pays the premiums and is the beneficiary of the life insurance policy on the key person. The amount of coverage needed reflects the expected amount of loss in income and sales caused by the key person's death, and the cost of hiring and training a replacement. The company cannot deduct the premiums from taxes; however, the death benefit is received tax free.

Employee Benefit Plans are given to employees as perks or privileges designed to provide incentive to join or remain with the company long-term. A few examples are: Executive Bonus Plans, Deferred Compensations Plans and Split Dollar Plans.

E. Social Security benefits and taxes
Social Security also known as Old Age, Survivors, and Disability Insurance (OASDI) was enacted by FDR in 1935. It provides benefits for most workers upon unemployment, disability, old age, or death.

Social Security benefit eligibility is based on the individual's insured status. Social Security has three types of insured status: fully, currently, and disability. The insured status is based on the quarters of credit earned, based on quarters of the year in which the individual worked and earned a minimum wage. Quarters are counted cumulatively, and do not have to be earned consecutively.

1. Fully Insured

To be eligible for all Social Security benefits, an individual must be fully insured, or earn at least 40 quarters of credit prior to age 62, the year of disability, or the year prior to death. Once a person earns at least 40 quarters of credit, the person is fully insured for the person's entire life.

2. Currently Insured

To be eligible for partial Social Security benefits, an individual must be currently insured, or earn at least 6 quarters of credit within the past 13 quarters. Currently insured person's partial benefits increase based on the number of quarters of credit earned.

3. Disability Insured

Eligibility for Social Security disability benefits is based on the "recent work test." Individuals must earn minimum quarters of credit within a period of time based on the individual's age. The minimum quarters of credit within a time period are:

- **6 quarters (1.5 years)** of credit within the past three years for individuals under the age 24
- **10 quarters (2.5 years)** of credit within the past five years for individuals under the age 31

- **20 quarters (5 years)** of credit within the past 10 years for individuals over age 31

Primary Insurance Amount

The primary insurance amount (PIA) is the average monthly wage of an individual and is used in determining the amount of the individual's Social Security retirement benefits.

Retirement Age

The full retirement age is 65 for covered workers who were born in 1937 or earlier. The full retirement age increases for individuals born between the years of 1938 to 1959 with the maximum retirement age set at age 67 for covered workers who were born in 1960 or later. The earliest age that an individual can receive Social Security retirement benefits is 62. The amount of the benefit will be lower than if the individual waited until his/her normal retirement.

Dual Benefit Eligibility

If an individual is eligible for dual Social Security benefits, the individual will receive the greater of the benefits, but not both.

Maximum Family Benefit for Survivors and Disability

A limit is placed on how much a covered worker and his family receives for Social Security survivors and disability benefits. The limit is indexed annually.

Earning Limits for Retirement

Once an individual reaches normal retirement age, the person is entitled to Social Security retirement benefits, whether or not the individual continues to work. However, if an individual elects to receive retirement benefits prior to attaining normal retirement age, the individual may be limited by the amount of money the person can earn without further reduction of benefits.

Social Security Benefits

Social Security benefits include several different types. The main benefits include: survivor, disability, and retirement benefits.

- **Survivor Benefits:** Survivor benefits pay a lump-sum death benefit or monthly income to survivors of deceased covered workers.
  Blackout Period: The Social Security blackout period is the time when the surviving spouse is ineligible to receive benefits. After the blackout period, the spouse is ineligible for survivor benefits until age 60.
- **Disability Benefits:** Social Security disability benefits are only available to covered persons who are fully and disability insured. Disability benefits begin after a five-month waiting period. Disability benefits are only available until age 65. The person must be unable to perform work done prior to disability due to physical and mental conditions that have or will last at least 12 months or result in death. Social Security does not pay partial or short-term disability benefits.
- **Retirement Benefits:** Social Security retirement benefits are only available to covered workers who are fully insured upon retirement. If a covered worker

retires at the normal retirement age, he will receive 100% of the PIA. However, if a covered worker retires early at the age of 62, the maximum Social Security benefit is 80% of the PIA. This reduction remains all through retirement. Retirement benefits pay covered retired workers at least 62 years of age, their spouses and other eligible dependents monthly retirement income.

Social Security Payroll Taxes: Social Security payroll taxes are collected from employers, employees and self-employed individuals.

Taxation of Social Security Benefits: Social Security benefit payments may be taxable if the individual's income is greater than a certain amount.

F. Tax treatment of insurance premiums, proceeds, and dividends

As a general rule, premiums for life insurance policies are not tax-deductible and proceeds from life insurance policies are tax-free if received in a lump sum. If proceeds are received in installments, a portion of the proceeds will contain interest, which is taxable.

1. Individual life

- **Premiums** for individually-purchased life insurance are not tax-deductible.
- **Death benefits** are tax-free if received in a lump-sum.
- **Interest:** If the benefit is paid in installments, the portion that is interest on the benefit is taxable. The cash value of a life insurance policy increases upon payment of premiums and interest accrued. If the policy is surrendered for cash value, the amount of interest is taxable. Otherwise, the benefit is tax-free.
- **Dividends** are considered a return of overcharged premium, and are not taxable since premiums are paid with after-tax dollars.
- **Loans** taken against the policy are repaid or recovered upon policy surrender or maturity, and are not taxable. If the policy is surrendered, the amount of cash value greater than premiums paid is taxable as income.
- **Accelerated benefits** are tax-free as long as the distribution is qualified, meaning the insured is terminally ill or expected to die within two years. Transfer of value occurs when the policy is sold to another party for consideration. While benefits are generally tax-free, if the policy's proceeds are a result of a transfer of value, the proceeds are taxable.

2. Group life

- Premiums paid by employees are not tax-deductible.
- The employer can deduct premium payments as a business expense.
- Proceeds are tax-free if received in a lump-sum.
- Benefits paid in installments are subject to taxation for the interest portion.

3. Modified Endowment Contracts (MECs)

MECs are overfunded life insurance policies and are subject to taxation. Congress and the IRS defined MECs to prevent individuals from using life insurance policies as investment vehicles simply to withdraw tax-free proceeds through partial surrenders. To determine whether a policy is defined as life insurance or a MEC, the IRS uses the seven-pay test. The seven-pay test requires premiums paid in the first seven years of the policy not exceed the level annual premium payments for a seven year paid-up policy, or the policy is defined as a MEC. MECs tax withdrawals on a last in, first out rule, which pays out interest first and is taxed as income. If withdrawals are made prior to age 59 ½, an additional 10% tax penalty is assessed, regardless of principal or interest. The death

benefit is tax-free.

Life Taxation Overview

	Premiums	Proceeds
Individual	Not tax-deductible	Tax-free if received in a lump-sum
Group	Premiums paid by employees are not tax-deductible	Tax-free if received in a lump-sum
MECs	The seven-pay test requires premiums paid in the first seven years of the policy not exceed the level annual premium payments for a seven year paid-up policy, or the policy is defined as a MEC. MECs tax withdrawals on a last in, first out rule, which pays out interest first and is taxed as income. If withdrawals are made prior to age 59 ½, an additional 10% tax penalty is assessed	Tax-free

TYPES OF HEALTH POLICIES

While life insurance covers the risk of loss caused by physical death, health insurance covers the risk of loss caused by a "living death." When a person sustains an accidental injury or sickness, medical expenses must be paid in addition to the normal living expenses. While a person is recovering, they may not be able to work, and as a result, their income is reduced. Health insurance is intended to insure the risk of income loss caused by accidental injury or illness and associated medical costs.

In this section we will review the different types of health insurance available to a prospective insured.

A. Disability income

The purpose of disability income insurance is to provide disabled individuals with periodic income while they cannot work. Disability income insurance prevents individuals from depleting their personal savings to afford the normal costs of living in addition to the medical expenses associated with disability. In other words, disability income policies serve as a substitute paycheck. It is important to note however, that while disability income policies are designed to cover costs of living while disabled, they are not designed to provide enough benefits to cover the costs of medical bills. For medical bill coverage, individuals should purchase a medical expense policy.

The following chart will give you a brief overview of the different types of disability insurance.

Disability Income Policies

Individual Disability Income	Provides benefits for loss of income

	resulting from accidental injury or sickness preventing the covered person from being able to work; Benefits are paid periodically, at least monthly, and are a fixed amount
Business Overhead Expense (BOE)	Help small businesses pay overhead expenses when the owner becomes disabled; Policy is owned by the business owner, who pays the premiums
Business Disability Buyout	Used to establish how ownership in a business is transferred upon an owner's disability
Group Disability Income	The employer or association owns a group contract providing insurance to a group of individuals; Designed to prevent overinsurance
Key Employee	Pays benefits to businesses when a key employee is disabled

Let's take a deeper look at these types of disability income insurance policies.

1. Individual disability income policy

Disability Income Insurance provides benefits for loss of income resulting from accidental injury or sickness preventing the covered person from being able to work. Benefit payments are paid periodically, at least monthly, and are a fixed amount or percentage (usually 60-70%) of the individual's lost income. The insured's occupation and earned income are the most important underwriting factors for disability insurance, but the cost of the policy is also determined by the definition of disability and the length of benefit and elimination periods.

Defining Total Disability

Individuals qualify for disability income benefits if they meet the insurer's definition of total disability. Insurers require the person to be unable to perform the work duties of his "own occupation" or "any occupation."

- Own Occupation disability income policies pay benefits when the insured cannot perform the work duties of his occupation. Own occupation benefits are limited to two years, and are reserved for individuals with specialized training.
- Any Occupation disability income policies are more restrictive, requiring the insured to be unable to perform the duties of any occupation in which the individual is qualified based on education, experience, or training.
- Presumptive Disability is a condition such as loss of sight, hearing, speech, or use of arms or legs, which qualifies as total disability, regardless of ability to work.

Accident vs. Sickness

Some disability income policies define total disability in terms of whether it resulted

from an accident or a sickness. Accidents policies use two definitions for accidents.

- *Accidental Means* definition is more restrictive and requires the injury to be unintentional and unexpected. In other words, the insured must be unaware that the risk would create a loss, and be unaware that the events leading up to the risks have the potential for loss.
- *Accidental Bodily Injury* definition covers all injuries except self-inflicted.

Sickness is any illness, disease, or condition appearing after the policy's effective date.

2. Business overhead expense policy

Business Overhead Expense (BOE) policies help small businesses pay overhead expenses when the owner becomes disabled. The business owner owns the policy and pays the premiums, but the benefits are used to pay the business' expenses such as rent, utility bills, and employee salaries. The BOE policy does not pay the owner's salary. BOE policies have elimination periods of 30 days or less and benefit periods of one to two years.

3. Business disability buy-sell policy

A disability buy-sell policy is used to establish how ownership in a business is transferred upon an owner's disability. Important facts include the following:

- The business owns the policy, pays premiums and receives the benefits.
- The benefit is used by the business to purchase the disabled owner's share in the business.
- The elimination period in buy-sell policies is one to two years.
- The benefits may be paid in monthly periodic payments or in a lump sum.

4. Group disability income policy

In group disability income policies, the employer, association or organization sponsors and owns the group contract. Group plans are generally designed to prevent "over insurance." Group policies do not usually require individual underwriting. Depending on the type of renewal provision, the insurance company may have the right to increase premiums on an entire class of insureds.

5. Key employee/partner policies

Key Person disability income policies pay benefits to businesses when a key employee is disabled. The purpose of the coverage is to allow the business to hire additional help while the employee is disabled. Key persons include:

- business owners,
- stockholders, and
- executive managers who are active in the company.

The amount of the disability income benefit is based on the key person's economic value to the business – the loss of income that would occur from reduced sales and hiring a replacement employee while the key person is disabled. Benefits may be paid as monthly periodic benefits, or in a lump sum. The business owns the policy, pays

the premiums, and receives the benefits. The key person is the insured individual, who must sign the application, consenting to the coverage.

B. Accidental death and dismemberment

Accidental death and dismemberment (AD&D) policies pay a lump sum payment if the insured dies in an accident, or loses major body parts in an accident. An AD&D policy covers loss that occurs within a certain time period of the accident, such as 90 days.

The AD&D policy pays a principal sum if the insured dies or loses both hands, both arms, both legs, or vision in both eyes due to an accident. If the insured only loses one extremity or vision in one eye, the policy will pay 50% of the principal sum.

C. Medical expense insurance

Medical expense plans cover the cost of medical care. They are indemnity contracts intended to indemnify or make whole the policyowner for medical costs resulting from a covered accident or sickness.

- Policies have deductibles and coinsurance, requiring the insured to share the cost.
- Medical expense plans pay benefits through reimbursement to the policyholder, on a service basis directly to the providers, or on an indemnity basis with fixed amounts based on the condition or service.

Here is an overview of the different types of Medical Expense Insurance:

Medical Expense Insurance

Type of Medical Expense Insurance	Characteristics
Basic Hospital, Medical, and Surgical	No deductibles or coinsurance; Low limits for catastrophic coverage
Major Medical Policies	Broad coverage; Higher limits for catastrophic coverage; Have deductibles, coinsurance, eligible expenses, and benefit limits
Health Maintenance Organizations (HMOs)	Prepaid plans focused on preventive care; Requires in-network referral to a specialist from primary care physician; Physicians paid by capitation
Preferred Provider Organizations (PPOs)	Group of medical facilities and physicians that provide services at a reduced cost; Insureds choose provider but benefits for non-preferred providers are reduced; Physicians paid on fee-for-service basis
Point of Service Plan (POS)	Mix of HMO and PPO; Members can choose in-network providers or out-of-network providers at an additional cost;

	Physicians paid by capitation
Flexible Spending Accounts (FSAs)	Tax-advantaged savings accounts; Funds used for qualified medical expenses
Health Reimbursement Accounts (HRAs)	Savings accounts with a high deductible health plan owned by employers for their employees; Contributions are made by employer
Health Savings Accounts (HSAs)	Savings account with a high deductible health plan owned by employee; Contributions are from employee's paycheck before tax

1. Basic hospital, medical, and surgical policies

Basic plans have no deductibles or coinsurance, and low limits for catastrophic coverage. Basic plans do not exist today as standalone contracts, but are still part of many modern insurance plans.

The three basic plans are medical, hospital, and surgical:

- Medical covers nonsurgical physician's fees for accident or sickness.
- Hospital covers costs of hospitalization except for physician's fees and surgeries.
- Surgical covers surgeon fees, anesthesia, and post-surgery recovery.

2. Major medical policies

Major medical policies provide broader coverage with higher limits for catastrophic coverage, and have deductibles, coinsurance, eligible expenses, and benefit limits.

There are several types of deductibles in major medical policies.

- Flat Dollar Deductible: The flat dollar deductible requires the insured to pay the deductible each time he receives a medical service. The insured pays the deductible for each claim.
- **Per Cause Deductible**: The per cause deductible is paid for each cause in which medical care is sought.
- **Maximum Annual Deductible**: A third type of deductible is the maximum annual deductible also referred to as an all cause, calendar year, or cumulative deductible per person or per family (family maximum deductible). Once the insured has cumulatively paid enough medical expenses out-of-pocket to fulfill the annual deductible, the policy will begin to pay benefits.

After the deductible is paid, coinsurance applies. The policy specifies what percentage of the medical expense the insurer and insured are responsible for paying. Usually, the insurer is responsible for the larger portion. One example of coinsurance is 80/20 in which case the insurer pays 80% and the insured pays 20%.

After coinsurance is paid, some major medical policies incorporate a **stop-loss** feature, also referred to as an **out-of-pocket limit**, which prevents the insured from incurring catastrophic loss. Once the insured's total out-of-pocket expenses reach the stop-loss

limit, the insurer pays the remaining eligible expenses. The insured's total out-of-pocket expenses are comprised of the total amount of deductibles and coinsurance paid. After the stop-loss limit is reached, the insurer will pay the remaining eligible expenses.

Inside Limits and Maximum Benefit

Inside limits are within a policy and place dollar limits for certain medical service. Most policies also have a maximum lifetime benefit per individual (usually $1 million).

Restoration of benefits

Some major medical policies include a feature called the restoration of benefits. This allows the maximum lifetime benefit to be restored to its original amount after a large portion of the benefits have been used.

3. Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) are prepaid plans focused on preventive care, requiring the insured to be referred to a specialist by the primary care physician. Facilities and physicians must be in-network providers contracted with the HMO. Physicians are paid by capitation. HMOs have the following characteristics:

- Before an HMO can offer coverage and benefits to the public, the HMO must obtain a certificate of authority from the state's Department of Insurance.
- The HMO owns or contracts with a clinic and staffs it. It subcontracts with a hospital.
- Members may use only the group facilities and primary care providers (PCPs).
- Only the PCP can refer a patient to a specialist or hospital.
- The HMO provides free preventative medical care (annual physical exams and routine well-child visits, immunizations, age related preventative treatment, etc.) in an effort to identify and treat problems early, thus promoting health and saving money.
- The HMO has control both of the producers and the purchasers of health care (the medical facilities and staff and the members who will use them). Thus, it stands a good chance of containing costs more efficiently than other managed care models.
- Each member of the HMO pays a specified monthly flat fee for membership.
- Each member must be provided with a description of the specific procedure for lodging and resolving any complaints about the plan.

4. Preferred Provider Organizations (PPOs)

Preferred Provider Organizations (PPOs) are a group of medical facilities and physicians that provide services at a reduced cost. Facilities and physicians are paid on a fee-for-service basis. Insureds are free to choose their service providers, but benefits for non-preferred providers are reduced. Examples include:

- large employers
- trade unions

- BlueCross BlueShield groups
- traditional insurance companies
- local groups of hospitals

5. Point of Service (POS) plans

Point-of-Service (POS) plans are a mix of HMO and PPO arrangements. Members can choose in-network or out-of-network providers, but pay more for out-of network except in emergencies. Physicians are paid by capitation.

- In-network Coverage

  In-network coverage means the insured receives care through the network of doctors and hospitals participating in the plan, and all care is coordinated by the insured's primary care physician, who acts as **gatekeeper**.

  The PCP is the "gatekeeper" and makes all referrals to specialists and all arrangements regarding hospitalization.

  In-network coverage is the highest level of coverage in the plan: the plan will pay more for medical services, and the insured won't have to submit claim forms.

- Out-of-network Coverage

  Out-of-network coverage applies when the insured receives care from a medical provider who does not participate in the plan's network of providers, and the care is not coordinated by the PCP.

  In out-of-network coverage, the insured usually pays more of the actual cost of care than if they had used in-network coverage, and they must also submit claim forms to receive benefits. Services rendered by non-preferred providers must be covered at a rate of *at least* 80 % of the coverage offered for the services of preferred providers.

  Note: Emergencies are exempted from the lower level of coverage in out-of-network service.

6. Flexible Spending Accounts (FSAs)

FSAs are tax-advantaged savings accounts in which funds are used for qualified medical expenses and dependent care. There are two types of FSAs: qualified medical expense accounts; and dependent care expense accounts.

An individual may reimburse qualified expenses for a spouse or dependents in either account. Funds in an FSA are subject to the use-it or lose-it rule, where all the funds must be used in the plan year. FSA funds can be used for a wide range of medical expenses such as over-the-counter drugs and child care.

- *Eligibility*

  FSA plans are established and offered through an employer for the benefit of its employees. Employee contributions are made through a voluntary withholding of wages/salary, which is often referred to as a salary reduction agreement. Some plans even involve employers contributing to the account, as well.

- *Contribution Limits*

  Prior to the *Patient Protection and Affordable Care Act* that was signed into law in 2010, there was no limit on the amount of money you or your employer could contribute to the accounts. There is now an annual limit for qualified medical expense accounts that is indexed annually. The limit is the maximum contribution that each employee may make for the year, regardless of whether the employee has a spouse or dependents whose expenses are also reimbursed through his or her qualified medical expense account.

- *Tax Benefits*

  FSA funds are not subject to federal income or Social Security taxes. Employees contribute a portion of their income earnings to the savings account pre-tax, which lowers their taxable income. In addition, withdrawals may be tax free if you are paying for qualified medical expenses.

7. Health Reimbursement Accounts (HRAs)

Health Reimbursement Accounts (HRAs) are savings accounts with a high deductible health plan established by employers for their employees. The employer sets aside funds for employee's medical expenses. Employees are reimbursed by their employer for their medical expenses. Contributions are made by the employer, not through employee-elected salary reductions.

- *Eligibility*

  HRAs are established and offered through an employer for the benefits of the employee. The employer makes contributions to the HRA, not the employee.

- *Contribution Limits*

  There are no contribution limits for HRAs.

- *Tax Benefits*

  Employer contributions are tax-deductible as a business expense. Benefits are not taxable to employees. The employer establishes employee eligibility rules and funds rollover.

8. High Deductible Health Plans (HDHPs) and related Health Savings Accounts (HSAs)

HSAs replaced Medical Savings Accounts in 2003. HSAs are a combination of a savings account and high deductible health plan. Funds in an HSA may be used by the individual, their spouse, and their dependents.

Deductibles may be embedded or non-embedded. An ***embedded deductible*** is when an HSA has two deductibles: an individual, and a family deductible. The individual deductible is embedded in the family deductible, permitting each family member the opportunity for the policy to cover their medical bills before the total family deductible is met. An HSA with a *non-embedded deductible* only has the family deductible. The entire deductible must be met before the plan pays any benefits. The deductible can be satisfied by one family member, or by several.

- *Eligibility*

To be eligible for an HSA, an employee must meet the following requirements:

- Cannot have other health insurance coverage (except disability income, long-term care or limited coverage);
- Cannot be eligible for Medicare; and
- Cannot be a dependent on another person's tax return.

- *Contribution Limits*

  HSAs have minimum deductibles and contribution limits that are indexed annually, as well as a maximum out-of-pocket spending, which is the maximum amount an individual must spend out-of-pocket before catastrophic coverage begins to pay 100% of qualifying medical expenses.

- *Tax Benefits*

  The employer and employees make contributions to health savings accounts. Contributions are vested immediately. Contributions are tax deductible for individuals and are made on a salary-reduction basis. Employer-made contributions are not taxable income to the employee.

  Funds in an HSA can be used tax-free (no tax on principal or interest) for qualified health expenses. If funds are used for non-health purchases, a 20% penalty, plus tax is assessed. Funds in an HSA rollover from year to year. Withdrawals made after the age of 65 for non-health purchases are taxed, but not penalized.

9. Stop loss

After coinsurance is paid, most major medical policies incorporate a stop-loss feature, also referred to as an out-of-pocket limit, which prevents the insured from incurring catastrophic loss.

Once the insured's total out-of-pocket expenses reach the stop-loss limit, the insurer pays the remaining eligible expenses.

Some policies specify they will cover 100% of eligible expense after a certain dollar amount of out-of-pocket expenses. Other policies may state that coinsurance will apply only to the next $5,000 of eligible expenses after the deductible is paid, after which the insurer will cover the remaining eligible expenses.

D. Medicare supplement policies

Medicare supplements help cover costs not paid by Medicare, such as deductibles, coinsurance, and actual charges. These policies have become practically a requirement for seniors due to the exclusions, limitations and copay requirements of Medicare. While it is possible to obtain a Medicare Supplement Policy prior to reaching age 65, most Medicare supplement policyholders are older, living on a fixed income, and apprehensive about dealing with insurance. For this reason, states have enacted strict guidelines for the formation of Medicare supplement contracts.

Medicare supplement policies must contain the following standard provisions:

- Duplicating the benefits of Medicare is prohibited.
- Policyholders must be provided a free look period of 30 days.

- An outline of coverage, detailing policy features, benefits and provisions, must be provided to applicants.
- Medicare Supplement policies must be guaranteed renewable or non-cancellable.
- The loss ratio (total amount of benefits paid out compared to the total amount of premium dollars collected) for Medicare Supplement policies must be at least 75% for group contracts and 65% for individual contracts.
- Accident and sickness losses are treated the same, and the accidental means test cannot be used.
- Medicare Supplement policies must automatically accommodate annual changes in Medicare coinsurance and deductibles.
- Once a Medicare policy has been in effect for a period of six months, benefits cannot be limited or denied because the individual has pre-existing conditions. Pre-existing conditions are defined as conditions for which medical treatment or advice was received by a physician in the six months prior to the policy effective date.
- Medicare Supplement policy limitations and exclusions cannot be more stringent than those of Medicare.
- Conversion to an individual policy must be offered if group Medicare Supplement coverage is terminated and not replaced.
- Individuals who become eligible to receive Medicaid benefits are permitted to suspend their Medicare Supplement policy if the request is made within 90 days of receiving Medicaid benefits for a maximum of two years. Upon ineligibility for Medicaid, the individual's coverage will automatically resume within 90 days of Medicaid benefits ending.

E. Group insurance

Group health insurance shares several of the same concepts of group life insurance. These include:

- Organizations may not be formed for the sole purpose of obtaining insurance;
- Most group insurance are employer groups;
- The employer holds the master contract, while the covered employee receives a certificate of insurance;
- Group insurance reduces adverse selection. This means that the benefit schedules are set;
- Administrative costs are lower; and
- Premiums are paid by the employer and are deductible as a business expense.

1. Group conversion

Group health plans must provide the right of all eligible persons covered under the group policy to convert to an individual policy without evidence of insurability.

Conversion privileges are effective if the person was terminated for any reason except involuntary termination for cause, lost coverage due to the entire class of coverage being discontinued, or the insured's dependent child reaches an age where coverage terminates.

Policies may require the individual to have been covered continuously for a set period of time, often no more than three months.

Coverage provided by a conversion policy usually provides benefits most similar to that provided under the group policy; however, the person may elect a lesser form of coverage.

Conversion must be made within 31 days of ineligibility in the group plan.

2. Differences between individual and group contracts

Group insurance provides insurance for many people under one master contract. The group is underwritten as a whole, not each individual. Each member insured under the group plan is issued a certificate of insurance as evidence of coverage. Members insured under the group plan are not party to the contract, only the insurance company and the group entity.

Group insurance, as compared to individual insurance policies, has the following distinctions:

- More people are covered by a group plan through their employer than by an individual insurance plan.
- It is typically easier to qualify for a group plan than an individual plan.
- The unit cost for group insurance is generally less than for a comparable individual plan.

Group health insurance policies are contracts between an insurer and an employer, union, or other association. Group health contracts are established for the benefit of the group members. People enrolling in Group health plans usually do not have to undergo a medical exam as a prerequisite to enrollment.

3. General concepts

Groups must exist naturally. The group contract is issued to the employer, union, or association, and each member or employee receives a certificate of coverage. The group health insurance policy is the master contract. The policyholder is the employer, union, or other association, not the insured members.
Group health insurance policies have the following standard provisions:

- Grace Period: 31 days is allotted for nonpayment of premium
- Incontestability: The policy is incontestable for at least 2 years
- Evidence of Insurability: Individuals do not have to prove evidence of insurability unless enrolling after the group enrollment period

Employer-sponsored Plans: Employer-sponsored plans make up the largest portion of group insurance. Employers may individually contract group coverage with an insurer or join with other employers in Multiple Employer Trusts (METs) or Multiple Employer Welfare Arrangements (MEWAs).

Rating: Group health insurance policy rates are usually based on experience rating in which premiums are based on the claims experience of the entire group. With community rating, premiums are based on the actual or projected costs of insureds in a particular geographic location with reference to insureds' age, gender, occupation and health. With community rating, each member pays the same premium.

Underwriting: Insurers of group plans evaluate the risk of the entire group, not each

individual.

- Coverage is accepted or denied and premiums are set based on evaluating the age, sex, and occupation of the group.
- Insurers may not request medical information of groups of 50 or more.
- Each member of the group has the same coverage, including eligibility requirements and probationary period.
- Plans may not unfairly discriminate against certain individuals and all eligible individuals must be permitted to enroll.

Participation Levels:

- Contributory Plans are funded by the employer and employee premiums, and require 75% participation of eligible employees.
- Noncontributory plans are fully funded by the employer, and require 100% participation of eligible employees.

Eligibility for Coverage: Open Enrollment is a 30-day period each year, in which all eligible employees must be permitted to enroll, change coverage, or add dependents.

- Proof of insurability is not required during open enrollment.
- Insurers and employers generally require employees to be full-time to be eligible, and often require a probationary period of 30-90 days before they are eligible for coverage.
- Eligible dependents include spouses, children (including stepchildren and adopted children), and dependent parents. Children age 19-23 are required to be unmarried and full-time students. Disabled children have no age limit.

Coordination of Benefits: In the event of more than one insurance policy, the primary policy will pay benefits according to its limits, and the secondary policy will pay the remainder to its limits.

Change of Insurance Companies: If the employer changes insurance companies, all eligible employees under the old plan are covered by the new plan without a probationary period, and coinsurance and deductibles are carried over.

Termination of Coverage: Employee coverage may only be terminated if the employee is terminated, fails to make premium payments, or exceeds maximum benefit limits.

4. COBRA

COBRA allows employees and their dependents to continue group health coverage after termination or loss of eligibility for up to 18 months (36 months for dependents). COBRA only applies to companies of 20 or more employees.

Coverage under COBRA must be requested within 60 days and may require payment of 102% of the premium rate under the group plan. COBRA ceases if the insured becomes eligible for Medicare, becomes insured under another group plan, fails to pay premiums, or the benefit period ends.

5. HIPAA

HIPAA was enacted to protect coverage of individuals and their families who change or

lose jobs. Individuals with at least 18 months of creditable coverage are guaranteed issue under the new employer's plan. Creditable coverage provides proof of insurance. Creditable coverage may be applied to reduce waiting periods and exclusions for preexisting conditions.

HIPAA requires guaranteed renewability for group insurance except for nonpayment of premiums, violations of terms, or fraud. HIPAA also established standards for Protected Health Information (PHI), which includes individuals' current and prior medical history.

F. Long Term Care (LTC)

While most individuals believe that Medicare will cover their expenses in the event that they need to be placed into a nursing home, Medicare will only do so if the insured is placed into a nursing home as a result of accident or sickness. Most individuals who need to be placed into a nursing home, are placed there because of an inability to take care of themselves or perform activities of daily living. That is what Long Term Care insurance is for. In this section, we will take a closer look at the definitions and provisions relating to Long Term Care insurance.

1. Individual LTC contracts

Long-term care (LTC) policies are intended to help individuals with daily activities they are no longer capable of performing themselves. LTC policies must provide coverage for at least 12 months (some states - 24 months). To be eligible for LTC benefits, the insured must be incapable of performing some of the activities of daily living (ADLs), such a bathing, dressing, eating, mobility, transferring, toileting, and continence. Most policies require inability to perform at least two ADLs or be cognitively impaired. Many policies have minimum age of 50 and maximum age of 89 for eligibility. LTC policies cannot require hospitalization prior to LTC nursing home coverage.

Levels of Care

Levels of care are the types of care covered by a LTC policy.

- Skilled Care: Nursing care and rehabilitation needed on a daily basis.
- Intermediate Care: Nursing care and rehabilitation needed occasionally.
- Custodial/Residential Care: Care provided to assist an individual with ADLs.
- Home Health Care: Care provided in an individual's home.
- Adult Day Care: Care provided to an individual who does not need 24-hour care. Adult day care may be provided in the home or at an adult day care facility.
- Respite Care: Care that allows an individual's primary caregiver to have a break from caregiving duties.

The benefit period of a LTC policy is the maximum period that benefits will be paid to an insured.

Optional Benefits

- Guarantee of Insurability: Benefit levels increase without the insured needing to prove insurability. The benefit increase is typically limited to 5% per year.
- Return of Premium: A portion of the premiums paid will be returned if an LTC policy is lapsed, or an insured dies before benefits are paid out.
- Hospice Care: Some LTC policies may provide care for hospice, which focuses on

providing pain management and comfort, rather than curing an individual's ailments.

Nonforfeiture Options

Only qualified LTC plans are required to provide nonforfeiture protection by federal law. Nonforfeiture provisions prevent policyholders from forfeiting policy cash values or benefits if the policy lapses.

Inflation Protection: Qualified LTC policies must provide inflation protection by federal law. Nonqualified LTC plans must offer inflation protection, but it does not have to be included in policies. Inflation protection allows the policy benefits to increase annually without requiring the insured to provide evidence of insurability.

Disclosures

LTC policies must provide a 30-day free look period. Policies cannot restrict coverage only to skilled care. Applicants must be given the shopper's guide (outline of coverage) prior to completing the application.

Elimination Period: Many LTC policies have an elimination period similar to that found in a disability income policy, after which LTC benefits begin. In the case of LTC, the elimination period is usually 30 days or longer, during which period the insured must be confined to a nursing facility.

Waiver of Premium: The insurer may include a provision which waives payment of premiums while the insured is receiving LTC benefits for a specified time period (usually 90 or 180 days). Premiums resume after LTC ceases.

Qualified LTC Plans

Qualified LTC plans are tax-qualified, allowing premiums to be deducted as a business expense for employers, and deducted based on age for individuals. Benefits are not taxable.

2. Group/voluntary LTC contracts

Individuals who are insured under group LTC coverage must be provided with the right to convert to individual LTC coverage upon termination of group coverage (unless termination is due to nonpayment of premium) without needing to provide evidence of insurability.

Individuals must apply for the individual coverage and pay the premium within 31 days of the group coverage termination date.

G. Limited Benefit Plans

Limited insurance provides specialized coverage such as AD&D, which only provides coverage for accidental death and dismemberment. Limited health insurance policies are also referred to as conditional contracts because they do not pay benefits unless specific conditions are met. Other limited policies include travel accident, hospital, income, credit health or disability, prescription, vision, dental, blanket coverage, and dread disease (cancer, heart disease, stroke, blindness, muscular dystrophy, multiple sclerosis, etc.)

1. Cancer (or specified diseases) plans and Critical Illness plans

Dread disease, also known as critical illness and specified disease policies, cover specific diseases.

An example of a dread disease policy is a cancer or heart disease policy.

Dread diseases occur infrequently, but when an individual does contract a dread disease, the medical costs associated with it can be extremely high.

Dread disease policies can offer relatively inexpensive coverage compared to full coverage medical expense plans, which may exclude coverage for dread disease, regardless.

2. Worksite (employer-sponsored) plans

Worksite plans are employer-sponsored plans, such as wellness plans which foster healthier lifestyles for employees. Such wellness plans focus on healthy diets and physical exercise.

3. Hospital indemnity plans

Hospital Income / Hospital Indemnity policies pay a flat dollar benefit for each day the insured is confined to a hospital. The dollar benefit varies by policy and may range from $50 to $200 per day. The income benefit may be paid daily, weekly, or monthly. The amount is not based on the insured's income earnings.

Premiums for hospital income are low because it is limited coverage. The insured is not restricted to using the hospital income benefit for medical purposes, and may use it for whatever purpose desired.

Once the insured is discharged from the hospital, the benefits cease. Hospital indemnity policies are often sold as riders to disability income policies, but may also be sold as standalone policies.

4. Dental

Dental benefits are typically not included in traditional medical expense plans. Dental benefits are more frequently sold as specialized medical expense plans on a group basis and rarely as individual policies. Dental plans can also be set up as employer group dental expense plans.

5. Vision

Vision expense plans cover the cost of annual eye exams, and either eyeglasses or contact lenses every two years. Vision care policies may be purchased separately, or in some cases are included in group health plans.

Vision plans may exclude sunglasses, replacement lenses or frames and medical or surgical costs that are covered by other health insurance policies.

HEALTH POLICY PROVISIONS, CLAUSES, AND RIDERS

The NAIC developed the Uniform Individual Accident and Sickness Policy Provisions Law also known as the model health insurance policy provisions. All states have adopted the NAIC model laws. The NAIC model provisions provide standardization for all individual health insurance policy provisions and identify the rights of the insurer and policyowner.

Each state or insurer's wording of the model provisions may have slight variations, but the general concepts are identical. If insurers word the provisions differently, the wording must be at least as favorable as the law provides.

A. Mandatory provisions

1. **Entire Contract:** The entire contract consists of the application, if attached, the policy, and any endorsements. Any change must be approved by the policyholder.

2. **Incontestability:** Policies are incontestable after two years, except for fraud. Policies may not deny, limit, or exclude coverage on the grounds of misstatement (except fraud) once the policy is incontestable.

3. **Grace Period:** A grace period must be offered to allow payment of delinquent premiums and the policy to remain in effect.

4. **Reinstatement:** Polices must allow for a period of reinstatement upon payment of current and past due premiums.

5. **Notice of Claim:** Notice of claims must be given to the insurer within 20 days of loss.

6. **Claim Forms:** If the insurer does not provide claim forms within 15 days of receiving notice, the insured may submit proof of loss on any form.

7. **Proof of Loss:** Written proof of loss must be provided to the insurer within 90 days after the date of loss. In no event, except for absence of legal capacity, may proof of loss be submitted after one year from the date of loss.

8. **Time of Payment of Claims:** Claims must be paid upon receipt of proof of loss. Periodic payment of claims must be made on at least a monthly basis.

9. **Payment of Claims:** Claims are paid to the insured or the medical service provider, except death benefits, which are paid to the designated beneficiary or the insured's estate.

10. **Physical Examination and Autopsy:** The insurer, at its own expense, has the right to examine the insured or autopsy, if reasonably required and not prohibited by law.

11. **Legal Action:** No legal action may be taken prior to 60 days after written proof of loss is provided to the insurer.

12. **Change of Beneficiary:** The policyowner has the right to change the beneficiary, unless an irrevocable designation is made.

13. **Misstatement of Age:** If the insured's age is misstated, benefits are based on the premiums paid had the policy been issued at the correct age.

B. Optional provisions

Change of Occupation: If the insured is injured or contracts sickness after having changed occupations to one classified as more hazardous than that stated in the policy, the insurer must pay only the portion of the indemnities provided in the policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such hazardous occupation.

C. Other provisions and clauses

1. Insuring clause: The insuring clause is the insurer's promise to pay benefits, typically located on the policy face.

2. Free look: Each policy must provide notice to the insured of the right to examine (free look) for a period of 10 days from the date of delivery to return for a full refund of premiums and fees.

3. Consideration clause: The consideration clause states the promises exchanged between the insured and the insurer.

4. Probationary period: A probationary period is the time between the effective date of the policy and date coverage begins.

5. Elimination period: The elimination period is the time between sickness, accident, or disability occurs and benefits become payable. Elimination periods are used in disability income and long-term care policies.

6. Waiver of premium: A waiver of premium provides continuation of coverage in the event of permanent and total disability without payment of premiums.

7. Exclusions: The following are common exclusions for health insurance policies:

- The consumption of alcohol or narcotics;
- Terroristic acts or other acts of war;
- Participation in a felony;
- Pre-existing conditions;
- Self-inflicted injuries;
- Injuries otherwise covered through Workers' Compensation coverage;

8. Preexisting conditions: Preexisting conditions are medical conditions for which the insured has previously sought treatment or advice. Preexisting conditions may be excluded or limited for a specified period.

9. Recurrent disability: Policies must state whether recurrent disability is an existing or new claim, or has elimination period.

10. Coinsurance: Coinsurance provides for payment of service by the insurer and insured, usually 80% and 20%.

11. Deductibles: Deductibles are the amount the insured must pay for services before benefits are payable.

12. Eligible expenses: Eligible expenses are benefits or services provided under the policy coverage.

13. Copayments: Copayments are fixed price schedule for services and are paid by the insured.

14. Pre-authorizations and prior approval requirements: It is approval by the insurer that may be required for some services or policies.

15. Usual, reasonable, and customary (URC) charges: The policy must be defined in the policy.

16. Lifetime, annual, or per cause maximum benefit limits: It caps payments by the insurer and can be annual, lifetime, or per incident.

D. Riders

Another name for policy riders is policy add-ons. Health insurance policies can be customized by adding policy riders or endorsements to meet the specific needs of a client. While a policy rider adds additional benefits to a health insurance policy, it also usually raises the premium amount.

1. Impairment/exclusions: Excludes coverage for a specific condition that would otherwise be covered under the policy.

2. Guaranteed insurability (Future Increase Option): Allows the insured to purchase additional disability income coverage at future dates regardless of insurability.

3. Multiple indemnity (double, triple): Provide for payment of double or triple the accidental death or dismemberment benefits based on the cause of death or specific type of dismemberment.

E. Rights of renewability

An insurance policy must contain a provision for renewability that is either noncancellable, guaranteed renewable, conditionally renewable, or optionally renewable. Single-term nonrenewable policies must provide a nonrenewable provision stating that the policy may not be renewed.

Rights of Renewability

Noncancelable	Insured has the right to continuation by making timely payment of premiums
Cancelable	Allows the insurer to cancel the policy at any time with notice; the insurer must returned unearned premiums
Guaranteed Renewable	Provides continuation to a specified age subject to payment of premiums; Premiums can be increased by classes of insureds
Conditionally Renewable	Allows the insurer the right to not renew for any reason specified in the policy; Premiums can be increased

Optionally Renewable	Allows the insurer the right to not renew for any reason; Premiums can be increased

1. Noncancelable: Provide the insured the right to continuation of coverage by making timely payment of premiums. No changes in coverage or premiums are permitted without the insured's consent. The noncancelable renewability provision is the same as the guaranteed renewable provision except that premiums cannot be increased.

2. Cancelable: Allow the insurer to cancel the policy at any time with notice, provided the insurer returns all unearned premiums.

3. Guaranteed renewable: Provide continuation of coverage to a specified age subject to payment of premiums, but allows premium increases by classes of insureds.

4. Conditionally renewable: Policies that allow the insurer the right to not renew for any reason specified in the policy and premiums can be increased.

5. Optionally renewable: Policies that allow the insurer the right to not renew for any reason, and premiums can be increased.

6. Period of time for renewal: The policy must state in the renewal provision the period of time provided to the insured to renew coverage. Depending on the policy and the state, the insurer may require the insured to renew coverage by submitting an application to the insurer or merely payment of the premium after the expiration date of the initial policy.

SOCIAL INSURANCE

It may be helpful to think of Medicare as Medical expense insurance coverage that we pay for and is triggered by a covered accident or illness, that insureds pay for during their working years and use during their retirement years. Medicare has deductibles and coinsurance.

Medicaid, however, is not insurance. Medicaid is aid. Insureds do not pay for it and it has no deductibles or copayments. Insureds become eligible if they experience a covered accident or sickness.

A. Medicare

Medicare is federally-funded social insurance for people age 65 and older. Individuals who qualify for Social Security disability, ESRD (End Stage Renal Disease), or Lou Gehrig's disease also qualify.

Medicare is funded by FICA payroll tax. Employers and employees each pay **1.45%** taxes, and self-employed individuals must pay the entire **2.9%.**

Medicare is administered by the Center for Medicaid Services (CMS). The CMS contracts with private organizations (called intermediaries) to enroll providers, process claims, and investigate fraud.

When Medicare was first introduced, it was composed of hospital and medical coverage (only Parts A and B), known as "Original Medicare." Since then, it has expanded to offer

managed care and prescription drug coverage. The four types of Medicare coverage include:

- Part A: Hospital Insurance
- Part B: Medical Insurance
- Part C: Managed Care (Medicare Advantage)
- Part D: Prescription Drug Coverage

Medicare

Part A	Hospital
Part B	Doctors
Part C	Medicare Advantage
Part D	Prescription Drugs

Individuals age 65 or older or those qualifying through disability, ESRD, or Lou Gehrig's disease are eligible for Medicare benefits if they are a legal resident for at least five consecutive years and have paid Medicare taxes for at least 10 years.

1. Primary, secondary payor

Medicare is the primary payor if the individual is retired. Medicare is secondary if the individual is currently employed and insured under an employer health plan, or is in the first 30 months of ESRD. Medicare is also secondary to no-fault insurance, liability, black lung benefits, and Workman's Compensation.

2. Medicare Parts A, B, C, D

Part A: Hospital Insurance

Medicare Part A provides hospital insurance, which covers inpatient care and some costs associated with skilled nursing, hospice, and home health care. Funding for Part A comes from FICA payroll taxes. Individuals may apply for Part A at age 65, or after a waiting period of 24 months for disability.

Initial enrollment is the seven-month period spanning the three months prior to and after reaching age 65. General enrollment is January 1st through March 31st. Special enrollment is for individuals delayed because of coverage by an employer group health plan.

Part A provides benefits for hospitalization except physician's fees.

- Days 1-60 require a deductible before payment of all approved charges.
- Days 61-90 require daily coinsurance before payment of all approved charges.
- After day 90, the individual begins to use lifetime reserve days (total 60 days).

Daily coinsurance is required prior to payment of all approved charges. After all lifetime reserve days have been used, the individual pays all costs out-of-pocket.

Part A provides benefits for skilled nursing facilities (SNF) after a three-day hospitalization. Days 1-20, Medicare pays all approved charges. Days 21-100 require daily coinsurance before payment of all approved charges. After day 100, the individual

is responsible for paying all costs.

Other Coverage

- **Blood:** An individual that needs blood while an inpatient must pay for the first three pints of blood received in a calendar year (blood deductible).
- **Home Health Care:** Home Health is provided for up to 100 days after an inpatient hospital stay.
- **Hospice Care:** Hospice is for individuals who have a terminal illness that is expected to result in death within six months. The terminal illness must be validated by a physician. Hospice care focuses on pain relief, not curing the individual. Medicare Part A covers all approved charges (except for room and board at home or in a nursing home) for hospice care including temporary inpatient hospital stays and inpatient respite care.
- **Respite Care:** Respite Care is temporary care that allows an individual's family member or caregiver to have time off from caring for the individual.

Part B: Medical Insurance

Medicare Part B provides medical insurance, which covers physician's fees, outpatient care, and preventive care. Part B is funded through monthly premium payments and federal revenue. Individuals covered by Part A are eligible for Part B. Part B requires monthly premiums based on income. Eligible individuals must enroll in Part B during the enrollment periods. Individuals pay an annual deductible and 20% of all covered charges. Medicare pays the remaining 80%. Part B also covers 100% of charges for home health visits and 80% of medical equipment.

Part B excludes coverage for private duty nurses, custodial care, home health care after 100 days, cosmetic surgery, the first three pints of blood, dental, vision, hearing, acupuncture, chiropractic care, and prescription drugs.

Claims Terminology, Appeals and Other Key Terms

- **Actual Charge:** A physician's or medical provider's actual bill for services rendered.
- **Advance Beneficiary Notice:** Individuals with Original Medicare may receive an advance beneficiary notice (ABN) from their medical providers. The ABN states which medical services Medicare will not or probably will not cover.
- **Appeal:** An appeal is an action that an individual can take if he disagrees with the payment of Medicare plans for medical services and prescription drugs.
- **Medicare Approved Charge:** The Medicare approved charge/amount is the dollar amount that Medicare considers to be the reasonable charge for a particular medical service.
- **Assignment:** Assignment occurs when physicians and medical providers accept the predetermined Medicare approved charge as full payment for covered services. Physicians and medical providers that do not accept assignment are permitted to charge higher rates than the Medicare approved charge; however, they cannot charge more than the limiting charge which is 15% higher than the Medicare approved charge.
- **Carriers:** Private organizations which administer Medicare Part B benefits. Each state or region has its own carrier.
- **Durable Medical Equipment:** Necessary medical equipment prescribed by a physician for use in an individual's home, such as walkers, wheel chairs, and

oxygen.

- **Excess Charge:** The difference between the actual charge and the Medicare approved charge.
- **Intermediaries:** Intermediaries, or fiscal intermediaries (FI), are private organizations contracted to administer Medicare Part A benefits, enroll medical providers and investigate fraud. Each state or region has its own intermediary.
- **Non-Participating:** Physicians, medical providers and suppliers who have the option of accepting Medicare assignment.
- **Participating Doctor or Suppliers:** Physicians, medical providers and suppliers who sign agreements to accept assignment for Medicare claims, charging the Medicare approved charge.
- **Peer Review Organizations:** Physicians and other medical professionals selected by the government to audit the quality of care received by Medicare patients.

Part C: Managed Care

Medicare Part C (Medicare Advantage) provides coverage of Parts A and B, as well as some prescription benefits, through private insurers approved by Medicare. The premium is combined for Parts A and B. An individual is eligible for Part C if enrolled in Parts A and B, lives in the service area, and doesn't have ESRD. Individuals may enroll during the initial or general enrollment period.

Part C is designed to cover Parts A and B, so an individual cannot have Part C coverage and a Medicare supplement policy. Because Part C has some prescription benefits, individuals who enroll in Parts C and D will automatically be disenrolled from Part C. Individuals with ESRD cannot join Part C.

Part D: Prescription Drug Coverage

Medicare Part D provides prescription drug coverage and is offered through private prescription drug plans approved by Medicare. Individuals must be enrolled in Parts A and B to receive Part D benefits. Individuals must enroll during the initial or general enrollment period. Part D requires and annual deductible and coinsurance of 25% of covered costs. Once the plan reaches $2,970, the individual must pay 79% of charges until meeting the out-of-pocket limit of $4,750 and Medicare pays the remainder. This is called the "doughnut hole."

B. Medicaid

Medicaid is a dually-funded state and federal welfare program providing health care coverage for individuals with limited incomes. Medicare and Medicaid are dual-eligible programs, meaning individuals may qualify and receive benefits from both.

To qualify for Medicaid nursing home and home health care benefits, the individual must demonstrate lack of means as well as be disabled, blind, or over age 65. Medicaid public assistance is for individuals with dependent children or who are blind, disabled, or pregnant.

Medicaid provides coverage for physician and nursing services, inpatient and outpatient hospital care, labs and x-rays, home health care, screenings and treatment, family planning, prescriptions, dental, private nursing, glasses, and supplies. Medicaid requires individuals to deplete or "spend down" resources before receiving benefits.

C. Social Security benefits

Supplemental Security Income (SSI) benefits are monthly income paid by Social Security to individuals with limited incomes, are disabled or blind, or are age 65 and older. SSI is different from Social Security benefits, and pays for an individuals' food, shelter and clothing needs.

OTHER HEALTH INSURANCE CONCEPTS

A. Total, partial, and residual disability

Individuals qualify for disability income benefits if they meet the insurer's definition of total disability. Insurers require the person to be unable to perform the work duties of his "own occupation" or "any occupation."

- Own Occupation disability income policies pay benefits when the insured cannot perform the work duties of his occupation. Own occupation benefits are limited to two years, and are reserved for individuals with specialized training.
- Any Occupation disability income policies are more restrictive, requiring the insured to be unable to perform the duties of any occupation in which the individual is qualified based on education, experience, or training.
- Presumptive Disability is a condition such as loss of sight, hearing, speech, or use of arms or legs, which qualifies as total disability, regardless of ability to work.

Partial Disability is the inability to perform one or more duties or the inability to work full-time. Partial disability benefits pay the portion of lost income (usually 50% of total disability benefits) for up to six months.

Residual Disability is when the insured returns to work after total disability, but is unable to perform some of his prior duties. Residual disability pays the difference in the insured's income before and after disability or 50% of total disability benefits.

B. Owner's rights

The policyowner (synonymous with policyholder) is the person who has all ownership rights under the policy (such as assignment and naming beneficiaries), pays premiums and accepts the policy when delivered. Group insurance contracts are between the insurer and the policyowner. The policyowner is the employer, association, labor union, trusteeship, or any other type of eligible group. The policyowner purchases and is the sponsor of the group contract for the benefit of its employees or members. The policyowner is issued a master contract and has control and ownership of the policy. Members insured under the group policy are not issued their own policy; instead, each member receives a certificate of insurance that serves as proof of insurance coverage.

C. Dependent children benefits

Dependents are the family members to whom coverage is extended. Children must be covered from the moment of birth or adoption; however, the insurer may require notification of the birth or adoption within 31 days in order to continue coverage. Coverage of dependent children must continue until age nineteen (19), or if the dependent child is unable to be employed due to mental or physical impairments and

is dependent on the policy owner for support, there is no age limit and coverage will continue.

D. Primary and contingent beneficiaries

The beneficiary is the named person or persons who receive policy benefits. Beneficiaries can be primary or contingent. Primary beneficiaries are first to receive any benefit payouts, while contingent beneficiaries are beneficiaries that receive benefits in the event the primary beneficiary is unable to do so (i.e. had predeceased the insured).

E. Modes of premium payments (annual, semiannual, etc.)

The payment of premiums provision stipulates:

- When premium payments are due,
- How they must be paid, and
- To whom they must be paid.

The *premium mode* is stipulated. Premium modes include:

- monthly,
- quarterly,
- semiannually or
- annually.

F. Nonduplication and coordination of benefits (e.g., primary vs. excess)

In the event the insured is covered by more than one policy for the same condition or benefit, the coordination of benefits provision defines the method for determining which insurance company is the primary insurer and which insurance company is the secondary insurer.

In order to protect against a disabled person receiving greater income by being disabled than they can earn by working, most group disability plans offset policy benefits with wage continuation plans, Social Security, and Workers' Compensation.

By using the coordination of benefits provisions, all these policies coordinate together in order to prevent duplication of benefits.

G. Occupational vs. non-occupational

Disability income policies can provide either occupational or nonoccupational coverage. Occupational policies pay disability income benefits regardless of whether the disability resulted from a work-related incident or not. Nonoccupational policies only pay benefits if the disability resulted outside of work or is not work-related and the insured is eligible for Workers' Compensation benefits.

H. Tax treatment of premiums and proceeds of insurance contracts (e.g., disability income and medical expenses, etc.)

Every insurance policy has direct or indirect tax consequences. The tax effect of health insurance benefits is based on whether premiums were taxed. If the premiums are tax-deductible, the benefits are taxed as income. If the premiums are

not tax-deductible, the benefits are tax-free, as long as they do not exceed the actual cost of medical expenses. The following chart provides an overview of the taxation of health insurance policies.

Health Policy Taxation

	Individual	Group
Disability Income	Premiums are not tax-deductible; Benefits are tax-free.	Premiums are tax-deductible as a business expense
Medical Expense	Premiums are tax-deductible only if an individual's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Benefits are tax-free.	Premiums paid by employer are tax-deductible; Premiums paid by the employee are tax-deductible only if an employee's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Benefits are received tax-free as long as they do not exceed the actual cost of medical expenses
Long Term Care	Premiums are tax-deductible only if an individual's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Benefits are tax-free.	Premiums are tax-deductible only if an employee's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Benefits are tax-free.
Medicare Supplement	Premiums are tax-deductible only if an individual's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Benefits are tax-free.	Premiums paid by employer are tax-deductible; Premiums paid by the employee are tax-deductible only if an employee's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Benefits are received tax-free as long as they do not exceed the actual cost of medical expenses

Personally-owned Health Insurance

The tax effect of health insurance benefits is based on whether premiums were taxed.

- Disability Income Insurance: Not tax-deductible; however, disability income benefits are tax-free.
- Medical Expense Insurance: Premiums are tax-deductible only if an individual's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Benefits are received tax-free.
- Long-term Care Insurance: Premiums are tax-deductible only if an individual's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Deductions are limited to a specified dollar amount per year based on the Consumer Price Index and the recipient's age; Benefits are received tax-free.
- Medicare Supplement: Premiums are tax-deductible only if an individual's

unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on the individual's tax return; Benefits are received tax-free.

Employer Group Health Insurance

- Disability Income: Premiums are tax-deductible as a business expense and not taxed as income of the employee.
- Medical and Dental Expense: Premiums paid by the employer are tax-deductible. Premiums paid by the employee are tax-deductible only if the employee's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Benefits are received tax-free as long as they do not exceed the actual cost of medical expenses.
- Long-term Care Insurance: Premiums are tax-deductible only if an employee's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Benefits are received tax-free as long as they do not exceed the actual cost of medical expenses.
- Medicare Supplement: Premiums are tax-deductible if paid by employer; If paid by employee, policies are tax-deductible only if an employee's unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Benefits are tax-free as long as they do not exceed the actual cost of medical expenses.
- Accidental Death and Dismemberment: Premiums paid by the employer are tax-deductible; Not taxable income to employee; Benefits are received tax-free.
- Medical Expense Coverage for Sole Proprietors and Partners: Tax-deductible as a business expense, not to exceed income earned that year; Premiums cannot be deducted if the individual is eligible for coverage under his or his spouse's employer-subsidized health plan; Benefits received tax-free as long as they do not exceed the actual cost of medical expenses.

Business Insurance

- Key Person Disability Income: Premiums are not tax-deductible as a business expense; however, the disability income benefits received by the business are tax-free.
- Buy-Sell Policy: Premiums are not tax-deductible as a business expense; however, the benefits are received tax-free.
- Overhead: Premiums are tax-deductible as a business expense. Benefits are taxable.
- Disability Reducing Term Insurance: Premiums are not tax-deductible for the business. Benefits are received tax-free.

Special Savings Plans

- Health Savings Accounts: By contributing to an HSA, plan participants reduce their adjustable gross income, lowering their tax responsibilities. Contributions to an HSA are made on a pre-tax basis; interest grows tax-deferred.
- Health Reimbursement Accounts: Employer contributions are tax-deductible as a business expense and are not part of the employee's taxable income. Benefits are received tax-free.
- Flexible Spending Accounts: Employees deduct pre-tax dollars from their income earnings and deposit them in an employer-sponsored FSA. Employees submit receipts for eligible medical expenses for reimbursement up to the annual

maximum.
- Consumer-Driven Plans: Consumer-driven healthcare plans combine the use of HSAs and HRAs to pay for routine medical expenses and high-deductible coverage. Eligible HSA withdrawals and HRA reimbursements are non-taxable.

Social Security Disability

- Payroll Tax: SSDI is a social program funded by payroll taxes withheld from every individual's paycheck. The tax is split between employers and employees.
- Benefits: Social Security Disability benefits are taxable based on the adjusted gross income of the individual.

I. Managed care

Managed care plans include Blue Cross and Blue Shield, in which subscribers can purchase HMO, PPO, and POS plans.

- **Health Maintenance Organizations (HMOs)** are prepaid plans focused on preventive care, requiring the insured to be referred to a specialist by the primary care physician. Facilities and physicians must be in-network providers contracted with the HMO. Physicians are paid by capitation.
- **Preferred Provider Organizations (PPOs)** are a group of medical facilities and physicians that provide services at a reduced cost. Facilities and physicians are paid on a fee-for-service basis. Insureds are free to choose their service providers, but benefits for non-preferred providers are reduced.
- **Point-of-Service (POS)** plans are a mix of HMO and PPO arrangements. Members can choose in-network or out-of-network providers, but pay more for out-of network except in emergencies. Physicians are paid by capitation.

J. Workers Compensation

Most employers are required to have Workers' Compensation insurance to cover accidental injury and sickness employees incur as a result of employment.

In order for an employee to be eligible for Workers' Compensation benefits, they must work for an employer that has Workers' Compensation insurance, and the employee must incur an accidental injury or sickness that occurs as a result of employment.

Workers' Compensation benefits include medical, disability income, death, and rehabilitation benefits.

Medical benefits are provided to an employee until the condition is completely treated or cured.

Disability income benefits are relatively small, but are paid after the employee undergoes a waiting period called an elimination period. If the disability extends beyond the elimination period, then disability income benefits will be paid in an amount of 66⅔% of weekly wages for a permanent total or temporary total disability. For partially disabled employees, the weekly benefit is equivalent to the percentage of wages lost due to inability to work.

Death benefits include a one-time burial payment and weekly income in an amount of 66⅔% of the deceased employee's weekly wage for a dependent spouse and children.

Each state has a maximum time and amount limit for weekly income benefits.

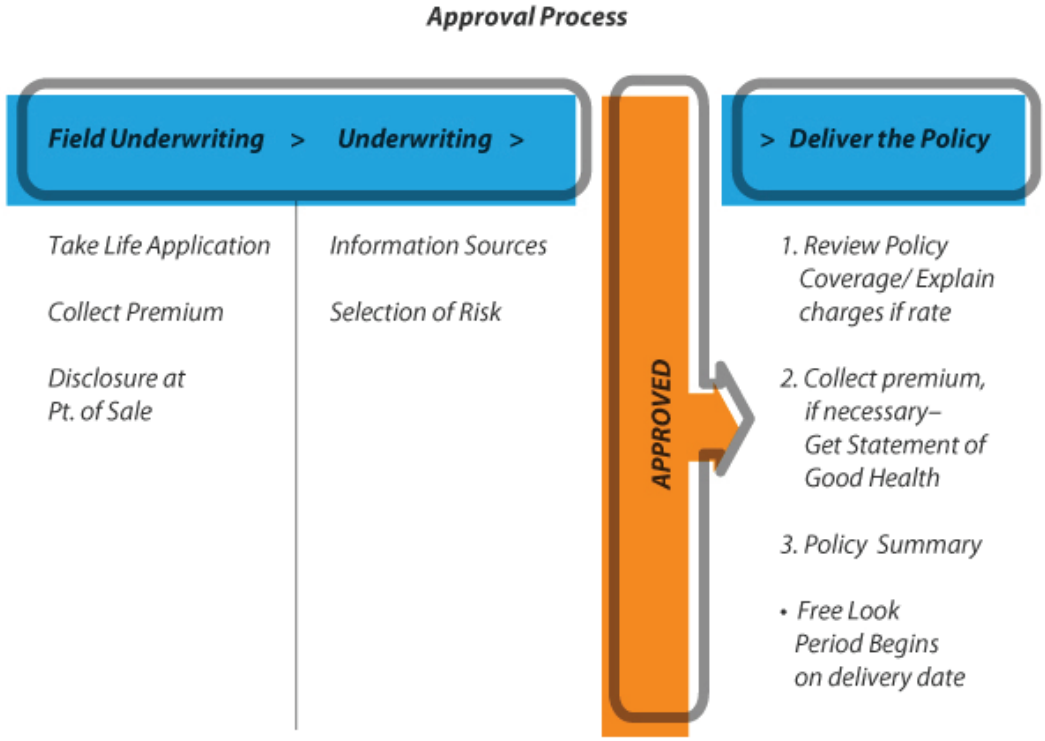
Rehabilitation benefits include physical and occupational therapy, medical equipment and cost of living expenses while the employee is being rehabilitated.

K. Subrogation

Subrogation is the right of the insurer to assume the rights of the insured and sue the responsible third party for damages inflicted upon the insured.

FIELD UNDERWRITING PROCEDURES

In this section we will cover the process involved with applying, issuing, and delivering insurance policies. The first step is completing the application. Next, the underwriting process helps determine the classification of risks and rates of the policy. And finally, we will look at the delivery of the policy.



A. Completing application

The application is one of the primary sources of information used in underwriting an insurance policy. The person who applies for coverage must complete and submit the application. In most cases, the application is attached to, and becomes part of the contract. The application is attached to the policy so that it becomes a legal part of the insurance contract. Therefore, if the insurer discovers intentional misstatements in the application, the application can be used as a legal document.

Required signatures
The agent and the applicant are required to sign the application. If the applicant is someone other than the proposed insured, except for a minor child, the proposed insured must also sign the application (in some states once a minor reaches the age of 15, the minor is eligible to contract for a life or health insurance policy). It is important for the agent to be present to witness any and all signatures. Disclosure forms and additional questionnaires that the applicant must complete must be signed by both the agent and the applicant. If automatic checking account drafts will be used for premium payment, the applicant must sign agreeing to such.

B. Explaining sources of insurability information (e.g., MIB Report, Fair Credit Reporting Act, etc.)

The Medical Information Bureau is a nonprofit trade organization which maintains medical information about individuals. Information from the MIB is used by life and health insurers. Member insurers supply the MIB with confidential aversive information about an applicant for insurability purposes. Information collected includes underwriting information such as an individual's hazardous activities and impairments to insurability; however, the MIB does not collect claims information or how much coverage an individual has. Insurers may access MIB information on an applicant only if needed for additional investigation. Insurers cannot refuse to issue policies solely on information supplied by the MIB.

Consumer Reports are any written, oral, or other communication of information by a consumer reporting agency about a consumer's credit worthiness, character, general reputation, personal characteristics or mode of living which are used to determine a consumer's eligibility for credit, insurance, employment, or other authorized purposes. The person seeking a consumer report on an individual must have a valid business need for the information.

Investigative Consumer Reports contain information on a consumer's character, general reputation, personal characteristics, or mode of living, but are obtained through personal interviews with neighbors, friends, or associates of the consumer. Investigative consumer reports cannot be performed unless the consumer has been notified in writing of the report within three days of when the report was initially requested.

The Fair Credit Reporting Act (FCRA) was passed in 1970 with the purpose of regulating the way credit information is collected and used. The Act requires consumer reporting agencies to implement policies and procedures to preserve the confidentiality, accuracy, relevance, and appropriate utilization of consumer's private credit information. There are two types of reports insurance underwriters will utilize to obtain credit information about an applicant:

- Consumer Reports and
- Investigative Consumer Reports.

Consumers must be informed that they have the right to request additional information about the report; such information must be provided to consumers within five days, if requested. Consumers must be informed at the time of application

that a consumer report may be requested, regardless of whether a report is actually ordered or not. Consumers should also be informed that they have the right to request additional information about the report, such as the name of the company that provided them with a report.

C. Initial premium payment and receipt and consequences of the receipt (e.g., medical examination, etc.)

Producers should make every effort to collect the initial premium with the application. The producer issues the applicant a premium receipt upon collecting the initial premium.

Conditional Receipt: The producer issues a conditional receipt to the applicant when the application and premium are collected. The conditional receipt denotes that coverage will be effective once certain conditions are met. If the insurer accepts the coverage as applied for, the coverage will take effect from the date of the application or medical exam, whichever is later. There are two types of conditional receipts: insurability and approval. The difference between the two receipts is when coverage begins. With the insurability receipt coverage begins on the application date or date of medical exam. The insurability receipt provides interim coverage as long as the applicant is insurable as applied for. If not, coverage is not effective. Unlike the insurability receipt, the approval receipt does not provide interim coverage; however, coverage begins when the application is approved by the insurer.

Binding Receipt: The binding receipt or the temporary insurance agreement provides coverage from the date of the application regardless of whether the applicant is insurable. Coverage usually lasts for 30 to 60 days, or until the insurer accepts or declines the coverage. Binding receipts are rarely used in life insurance, and are primarily used in auto and homeowners insurance.

D. Submitting application (and initial premium if collected) to company for underwriting

The agent's report, which is used for underwriting, but does not become part of the contract, includes the following information:

- their observations of the applicant,
- information about the applicant's financial condition,
- the applicant's background,
- the applicant's character, and
- a disclosure of the agent's relationship to the applicant.

An agent should complete the agent's report before sending the completed application to the insurer's home office.

Once the underwriter establishes that an applicant is insurable, the underwriting process begins. The underwriter will:

- evaluate information about the applicant and
- select a risk classification and premium rate that matches the

degree of risk undertaken.

After the application clears underwriting, the insurer will issue the policy for delivery, and the insurance producer will deliver the policy to the policyowner.

E. Ensuring delivery of policy and related documents to client

A policy is delivered after the insurer approves the application and issues the policy for delivery. The policy does not take effect until the initial premium has been collected, the application approved, and the policy is issued and delivered. Some insurers require a Statement of Good Health to be signed and collected from the insured, verifying that the insured has not become ill, injured, or disabled during the policy approval process.

F. Explaining policy and its provisions, riders, exclusions, and ratings to clients

The applicant must receive a document explaining the coverage purchased, policy provisions, riders, exclusions, and the names of the insurer and agent. In health insurance, this is called the **outline of coverage**.

G. Replacement
Part 1 of the application includes information about existing policies if the proposed coverage is intended to replace existing coverage. If the agent discovers that the proposed coverage is replacing existing coverage, the policy is considered a replacement, meaning that the agent must comply with certain regulations regarding replacement.

H. Contract law

In this section, we will discuss general contract law including the essential elements of a contract, terms and concepts, and how they apply to the insurance contract.

Insurance policies are legal contracts. A **contract** is a legally binding agreement between two or more parties where a promise of benefits is exchanged for valuable consideration.

1. Elements of a contract

Four elements must be present in every contract to be valid and legally enforceable. These elements include:

- Offer and acceptance,
- Consideration,
- Competent parties, and
- Legal purpose.

2. Insurable interest

Insurable interest states that an individual must have a valid concern for the continuation of the life or well being of the person insured. Insurable interest must be shown when an individual applies for a life or health insurance policy. When the insured becomes sick, injured or dies, insurable interest does not need to be shown.

An insurance contract must be legal and not in opposition of public policy. If an insurance contract has insurable interest and the insured has provided written consent, it has legal purpose. Insurable interest must exist at the time of application.

3. Warranties and representations

Warranties are statements that are guaranteed to be true and are part of the legal contract. Breach of warranty is grounds for voiding an insurance contract. Representations are statements made by the insured, to the best of his knowledge.

4. Unique aspects of the health contract

The most important factors in underwriting a health insurance policy are:

- physical condition,
- moral hazards, and
- occupation.

Physical Condition: An applicant's physical condition is the most important factor in evaluating health risks.
Moral Hazards: An applicant's lifestyle and habits also have an effect on risk selection and classification.
Occupation: An applicant's occupation is important for predicting the likelihood and severity of a disability.

a. Conditional: Insurance contracts are conditional because certain conditions must be met by all parties to the contract when a loss occurs in order for the contract to be legally enforceable.

b. Unilateral: Insurance contracts are said to be unilateral because they are one-sided. Only the insurance company makes legally enforceable promises to pay benefits in the event of a covered loss. The applicant does not make any legally enforceable promises to the insurance company, not even the payment of premiums. However, if the applicant fails to pay premiums, the insurance company has the right to cancel the contract.

c. Adhesion: Insurance contracts are contracts of adhesion. In a contract of adhesion there is only one author – the insurance company. The applicant does not write any part of the insurance contract. Therefore, insurance companies must adhere to the insurance policy. Insurance contracts are often referred to as "take it or leave it" contracts because the insurance company writes the insurance contract, to which the insured must adhere.

Unique Aspects of Contracts

Conditional	Certain conditions must be met by all parties to the contract when a loss occurs in order for the contract to be legally enforceable
Unilateral	One-sided agreements; only the insurer

	is legally bound
Adhesion	Take it or leave it contract; the insured has no say in the contract terms or conditions