Addendum: for use with North Dakota Life and Health online ExamFX courses and study guide version 22109en/22110en, per exam provider switch and outline updates effective 9/1/2019.

Please note that North Dakota is changing testing providers. Effective 9/1/2019, state insurance exams will be administered by Prometric. For additional information about exam requirements and complete exam content outlines, please refer to the testing provider's website: https://www.prometric.com/en-us/Pages/home.aspx

New exam breakdowns:

North Dakota Life Insurance
110 Total Questions (100 scored; 10 pretest)
Time Limit: 120 minutes

Chapter	Percent of Exam
General Knowledge	
General Insurance	9%
Life Insurance Basics	11%
Life Insurance Policies	10%
Life Insurance Policy Provisions, Options, and Riders	10%
Annuities	9%
Qualified Plans	5%
Federal Tax Considerations for Life Insurance and Annuities	6%
Laws and Regulations	
Insurance Regulation	12%
North Dakota Laws and Regulations Pertaining to Life Insurance and Annuities	28%

North Dakota Accident and Health Insurance Examination
110 Total Questions (100 scored; 10 pretest)
Time Limit: 120 minutes

Chapter	Percent of Exam
General Knowledge	
General Insurance	9%
Health Insurance Basics	8%
Individual Health Insurance Policy General Provisions	7%
Disability Income and Related Insurance	6%
Medical Plans	6%

Group Health Insurance	6%
Dental Insurance	2%
Insurance for Senior Citizens and Special Needs Individuals	10%
Federal Tax Considerations for Health Insurance	6%
Laws and Regulations	
Insurance Regulation	10%
North Dakota Laws and Regulations Pertaining to Accident and Health Insurance	30%

*The following are **content additions** to supplement your existing text unless otherwise indicated.*

Insurance Regulation (LIFE & HEALTH)

Federal Regulation

Fraud and False Statements, Including 1033 Waiver

It is considered **unlawful insurance fraud** for any person engaged in the business of insurance to willfully, and with the intent to deceive, make any oral or written statement that are either false or omit material facts. This includes information and statements made on an application for insurance, renewal of a policy, claims for payment or benefits, premiums paid, and financial condition of an insurer.

Anyone engaged in the business of insurance whose activities affect interstate commerce, and who knowingly makes false material statements may be fined, imprisoned for up to **10 years** or both. If the activity jeopardized the security of the accompanied insurer, the punishment can be up to **15 years**.

Anyone acting as an officer, director, agent or other insurance employee who is convicted of embezzling funds faces the aforementioned fines and imprisonment. However, if the embezzlement was in an amount less than **$5,000**, prison time may be reduced to 1 year.

Federal law makes it illegal for any individual convicted of a crime involving dishonesty, breach of trust or a violation of the Violent Crime Control and Law Enforcement Act of 1994 to work in the business of insurance affecting interstate commerce without receiving written consent from an insurance regulatory official (Director of Insurance, or Commissioner of Insurance) - a **1033 waiver**. The consent of the official must specify that it is granted for the purpose of 18 U.S.C. 1033. Anyone convicted of a felony involving dishonesty or breach of trust, who also engages in the business of insurance, will be fined, imprisoned for up to 5 years or both.

Section 1034, Civil Penalties and Injunctions for Violations of Section 1033, states that the Attorney General may bring a **civil action** in the appropriate U.S. district court against any person who engages in conduct that is in violation of Section 1033 of not more than **$50,000** for each violation, or the amount of compensation the person received as a result of the prohibited conduct, whichever is greater.

General Insurance (LIFE & HEALTH)

A. Risk Management Key Terms

1. Risk

Risk is the uncertainty or chance of a loss occurring. The two types of risks are pure and speculative, only one of which is insurable.

- **Pure risk** refers to situations that can only result in a loss or no change. There is no opportunity for financial gain. Pure risk is the only type of risk that insurance companies are willing to accept.
- **Speculative risk** involves the opportunity for either loss or gain. An example of speculative risk is gambling. These types of risks are not insurable.

2. Hazard

Hazards are conditions or situations that increase the probability of an insured loss occurring. Hazards are classified as physical hazards, moral hazards, or morale hazards. Conditions such as lifestyle and existing health, or activities such as scuba diving, are hazards and may increase the chance of a loss occurring.

Physical hazards are individual characteristics that increase the chances of the cause of loss. Physical hazards exist because of a physical condition, past medical history, or a condition at birth, such as blindness.

Moral hazards are tendencies towards increased risk. Moral hazards involve evaluating the character and reputation of the proposed insured. Moral hazards refer to those applicants who may lie on an application for insurance, or in the past, have submitted fraudulent claims against an insurer.

Morale hazards are similar to moral hazards, except that they arise from a state of mind that causes indifference to loss, such as carelessness. Actions taken without forethought may cause physical injuries.

3. Peril

Perils are the **causes** of loss insured against in an insurance policy.

- *Life insurance* insures against the financial loss caused by the premature death of the insured;
- *Health insurance* insures against the medical expenses and/or loss of income caused by the insured's sickness or accidental injury;
- *Property insurance* insures against the loss of physical property or the loss of its income-producing abilities;
- *Casualty insurance* insures against the loss and/or damage of property and resulting liabilities.

4. Loss

Loss is defined as the reduction, decrease, or disappearance of value of the person or property insured in a policy, caused by a named peril. Insurance provides a means to transfer loss.

B. Methods of Handling Risk

Sharing is a method of dealing with risk for a group of individual persons or businesses with the same or similar exposure to loss to share the losses that occur within that group. A reciprocal insurance exchange is a formal risk-sharing arrangement.

The most effective way to handle risk is to **transfer** it so that the loss is borne by another party. Insurance is the most common method of transferring risk from an individual or group to an insurance company. Though the purchasing of insurance will not eliminate the risk of death or illness, it relieves the insured of the financial losses these risks bring.

There are several ways to transfer risk, such as hold harmless agreements and other contractual agreements, but the safest and most common method is to purchase insurance coverage.

One of the methods of dealing with risk is **avoidance**, which means eliminating exposure to a loss. *For example,* if a person wanted to avoid the risk of being killed in an airplane crash, he/she might choose never to fly in an airplane. Risk avoidance is effective, but seldom practical.

Risk **retention** is the planned assumption of risk by an insured through the use of deductibles, co-payments, or self-insurance. It is also known as self-insurance when the insured accepts the responsibility for the loss before the insurance company pays. The purpose of retention is

1. To reduce expenses and improve cash flow;
2. To increase control of claim reserving and claims settlements; and
3. To fund for losses that cannot be insured.

Since we usually cannot avoid risk entirely, we often attempt to lessen the possibility or severity of a loss. **Reduction** would include actions such as installing smoke detectors in our homes, having an annual physical to detect health problems early, or perhaps making a change in our lifestyles.

C. Elements of Insurance Risk

Not all risks are insurable. As noted earlier, insurers will insure only **pure risks,** or those that involve only the chance of loss with no chance of gain. Furthermore, even pure risks must have certain characteristics in order to be insurable.

Insurable risks involve the following characteristics:

- **Due to chance:** a loss that is outside the insured's control.
- **Definite and measurable:** a loss that is specific as to the cause, time, place and amount. An insurer must be able to determine how much the benefit will be and when it becomes payable.
- **Statistically predictable:** Insurers must be able to estimate the average frequency and severity of future losses and set appropriate premium rates. (In life and health insurance, the use of mortality tables and morbidity tables allows the insurer to project losses based on statistics.)
- **Not catastrophic:** Insurers need to be reasonably certain their losses will not exceed specific limits. That is why insurance policies usually exclude coverage for loss caused by war or nuclear events: There is no statistical data that allows for the development of rates that would be necessary to cover losses from events of this nature.
- **Randomly selected and large loss exposure:** There must be a sufficiently large pool of the insured that represents a random selection of risks in terms of age, gender, occupation, health and economic status, and geographic location.

D. Adverse Selection

Insurance companies strive to protect themselves from **adverse selection,** the insuring of risks that are more prone to losses than the average risk. Poorer risks tend to seek insurance or file claims to a greater extent than better risks.

To protect themselves from adverse selection, insurance companies have an option to refuse or restrict coverage for bad risks, or charge them a higher rate for insurance coverage.

E. Law of Large Numbers

The basis of insurance is sharing risk among a large pool of people with a similar exposure to loss (a homogeneous group). The **law of large numbers** states that the larger the number of people with a similar exposure to loss, the more predictable actual losses will be. This law forms the basis for statistical prediction of loss upon which insurance rates are calculated.

F. Insurers

1. Types of Insurers

Fraternal Benefit Societies

A **fraternal benefit society** is an organization formed to provide insurance benefits for members of an affiliated lodge, religious organization, or fraternal organization with a representative form of government. Fraternals sell only to their members and are considered charitable institutions, and *not insurers.* They are not subject to all of the regulations that apply to the insurers that offer coverage to the public at large.

Risk Purchasing Groups

A **risk purchasing group** is an entity which offers insurance to groups of similar businesses with similar exposures to risk. The policy is based on the insured's loss and expense experience and is not afforded to other policyholders with respect to rates, policy forms, or coverages. Such programs and the groups that offer them are exempt from most state laws, rules, and regulations, except for the state in which the group is domiciled.

Self-Insurance Groups

Self-insuring is when a person or entity, as an alternative to the purchase of insurance from an insurance company, develops a formal program identifying, evaluating and funding its losses. It is frequently used for workers compensation where losses are fairly predictable, and states have established regulations for self-insurance.

Self-insurers frequently structure their programs to only retain losses up to a certain specified limit and purchase insurance to cover loss above that level. (This is called stop-loss coverage.)

2. Marketing (Distribution) Systems

Insurance companies market their products in different ways: through agents or direct solicitation to the customers.

TYPE OF MARKETING ARRANGEMENTS	CHARACTERISTICS
Independent Agency System/ American Agency System	▪ 1 independent agent represents several companies ▪ Nonexclusive ▪ Commissions on personal sales ▪ Business renewal with any company
Exclusive Agency System/ Captive Agents	▪ 1 agent represents 1 company ▪ Exclusive ▪ Commissions on personal sales ▪ Renewals can only be placed with the appointing insurer
General Agency System	▪ General agent-entrepreneur represents 1 company ▪ Exclusive ▪ Compensation and commissions ▪ Appoints subagents
Managerial System	▪ Branch manager (supervises agents) ▪ Salaried ▪ Agents can be insurer’s employees or independent contractors

Direct Response Marketing System	▪ No agents ▪ Company advertises directly to consumers (through mail, Internet, television, other mass marketing) ▪ Consumers apply directly to the company

3. Financial Status (Independent Ratings Services)

The financial strength and stability of an insurance company are two vitally important factors to potential insureds. The financial strength of an insurance company is based on prior claims experience, investment earnings, level of reserves (amount of money kept in a separate account to cover debts to policyholders), and management, to name a few. Guides to insurance companies' financial integrity are published regularly by the following various independent rating services:

- AM Best
- Fitch
- Standard and Poor's
- Moody's
- Weiss

4. Authority and Powers of Producers

An agent/producer is an individual licensed to sell, solicit or negotiate insurance contracts on behalf of the **principal (insurer).** The **law of agency** defines the relationship between the principal and the agent/producer: the acts of the agent/producer within the scope of authority are deemed to be the acts of the insurer.

In this relationship, it is a given that

- An agent represents the insurer, not the insured;
- Any knowledge of the agent is presumed to be knowledge of the insurer;
- If the agent is working within the conditions of his/her contract, the insurer is fully responsible;
- When the insured submits payment to the agent, it is the same as submitting a payment to the insurer.

The agent is responsible for accurately completing applications for insurance; submitting the application to the insurer for underwriting; and delivering the policy to the policyowner.

The agency contract details the authority an agent has within his/her company. Contractually, only those actions for which the agent is authorized can bind the principal (insurer). In reality, an agent's authority is much broader. There are 3 types of agent authority: express, implied, and apparent.

Express

Express authority is the authority a principal intends to grant to an agent by means of the agent's contract. It is the authority that is written in the contract.

Implied

Implied authority is authority that is **not expressed or written into the contract, but which the agent is assumed to have in order to transact the business** of insurance for the principal. Implied authority is incidental to and derives from express authority since not every single detail of an agent's authority can be spelled out in the written contract.

Apparent

Apparent authority (also known as *perceived* authority) is the appearance or the assumption of authority based on the actions, words, or deeds of the principal or because of circumstances the principal created. *For example,* when an insurer furnishes an agent with a rate book, application forms, and sales literature, the insurer cannot later deny that such a relationship existed.

5. Responsibilities to the Applicant/Insured

Although the agents act for the insurer, they are legally obligated to treat applicants and insureds in an ethical manner. Because an agent handles the funds of the insured and the insurer, he/she has **fiduciary responsibility**. A *fiduciary* is someone in a position of trust. More specifically, it is illegal for insurance producers to commingle premiums collected from the applicants with their own personal funds.

Market conduct describes the way companies and producers should conduct their business. It is a **Code of Ethics** for producers. Producers must adhere to certain established procedures, and failure to comply will result in penalties. Some of the market conduct regulations include, but are not limited to, the following:

- Conflict of interest;
- A request of a gift or loan as a condition to complete business; and
- Supplying confidential information.

Producers are required to perform in a professional manner at all times. *Professionalism* means that a person is engaged in an occupation requiring an advanced level of training, knowledge, or skill. Being professional means placing the public's interest above one's own in all situations. Any deviation could result in a penalty.

G. Contracts

1. Distinct Characteristics of an Insurance Contract

In addition to required elements, insurance contracts have unique characteristics that distinguish them from other types of legal contracts. It is important to understand these features and how they affect parties to an insurance contract.

Contract of Adhesion

A ***contract of adhesion*** is prepared by one of the parties (insurer) and accepted or rejected by the other party (insured). Insurance policies are not drawn up through negotiations, and an insured has little to say about its provisions. In other words, insurance contracts are offered on a take-it-or-leave-it basis by an insurer. Any ambiguities in the contract will be settled in favor of the insured.

Aleatory Contract

Insurance contracts are **aleatory,** which means there is an exchange of unequal amounts or values. The premium paid by the insured is small in relation to the amount that will be paid by the insurer in the event of loss.

Unilateral Contract

In a **unilateral contract,** only one of the parties to the contract is legally bound to do anything. The insured makes no legally binding promises. However, an insurer is legally bound to pay losses covered by a policy in force.

Personal Contract

In general, an insurance contract is a **personal contract** because it is between the insurance company and an individual. Because the company has a right to decide with whom it will and will not do business, the insured cannot be changed to someone else without the written consent of the insurer, nor can the owner transfer the contract to another person without the insurer's approval. Life insurance is an exception to this rule: A policyowner can transfer (or assign) ownership to another person. However, the insurer must still be notified in writing.

Conditional Contract

As the name implies, a **conditional contract** requires that certain conditions must be met by the policyowner and the company in order for the contract to be executed, and before each party fulfills its obligations. *For example*, the insured must pay the premium and provide proof of loss in order for the insurer to cover a claim.

2. Legal Interpretations Affecting Contracts

Indemnity

Indemnity (sometimes referred to as **reimbursement**) is a provision in an insurance policy that states that in the event of loss, an insured or a beneficiary is permitted to collect only to the extent of the financial loss, and is not allowed to gain financially because of the existence of an insurance contract. The purpose of insurance is to restore, but not let an insured or a beneficiary profit from the loss.

Reasonable Expectations

It is not always practical or necessary to state every direct and indirect provision or coverage offered by an insurance policy. If an agent implies through advertising, sales literature or statements that these provisions exist, an insured could **reasonably expect coverage**. *For example,* if an insurance company advertises in large print that insurance is available regardless of pre-existing conditions, the buyer could reasonably expect any pre-existing conditions to be covered, even if the small print on the back of the sales brochure specifies that not all pre-existing conditions would be covered.

Utmost Good Faith

The principle of **utmost good faith** implies that there will be no fraud, misrepresentation or concealment between the parties. As it pertains to insurance policies, both the insurer and insured must be able to rely on the other for relevant information. The insured is expected to provide accurate information on the application for insurance, and the insurer must clearly and truthfully describe policy features and benefits, and must not conceal or mislead the insured.

Ambiguities in a contract of adhesion

Because only the insurance company has the right to draw up a contract, and the insured has to adhere to the contract as issued, the courts have held that any ambiguity in the contract should be interpreted **in favor of the insured.**

Concealment

Concealment is the legal term for the intentional withholding of information of a material fact that is crucial in making a decision. In insurance, concealment is the withholding of information by the applicant that will result in an imprecise underwriting decision. Concealment may void a policy.

Fraud

Fraud is the intentional misrepresentation or intentional concealment of a material fact used to induce another party to make or refrain from making a contract, or to deceive or cheat a party. Fraud is grounds for voiding an insurance contract.

Waiver and Estoppel

Waiver is the voluntary act of relinquishing a legal right, claim or privilege. **Estoppel** is a legal process that can be used to prevent a party to a contract from re-asserting a right or privilege after that right or privilege has been waived. Estoppel is a legal consequence of a waiver.

LIFE ONLY

Life Insurance Basics

A. Life Settlement Act

The term **life settlement** refers to any financial transaction in which the owner of a life insurance policy sells a life insurance policy to a third party for some form of compensation, usually cash. A life settlement would require an absolute assignment of all rights to the policy from the original policyowner to the new policyowner.

Policyowners may choose to sell their policies because they feel they no longer need their coverage, or the premium costs have grown too high to justify continuation of the policy. In many cases, however, life settlement transactions are offered to senior citizens who may have a life-threatening illness and a short life expectancy. In these situations, the owner may elect to sell the policy to a life settlement provider for an amount greater than what they would receive if they surrendered the policy for cash value.

Definitions

Because Life Settlements are not involved in the establishment of new life insurance coverage, the Life Settlement Act defines terms that are not in conflict with the sale of the original life insurance coverage, but which accurately identify the distinctions in the Life Settlement business. Some of the more important definitions are as follows:

The term **business of life settlement** refers to **any** activity relating to the solicitation and sale of a life settlement contract to a third party who has no insurable interest in the insured.

The term **owner** refers to the owner of the life insurance policy who seeks to enter into a life settlement contract. The term does not include an insurance provider, a qualified institutional buyer, a financing entity, a special purpose entity, or a related provider trust.

Insured is the person covered under the policy that is considered for sale in a life settlement contract.

Qualified Institutional Buyer is one that owns and invests at least $100 million in securities and is allowed by the SEC to trade in unregistered securities. A life settlement provider may sell, or in some other manner approved by the Department of Insurance, transfer ownership of a settled policy to a qualified institutional buyer or other approved investment entity.

Life Expectancy is an important concept in life settlement contracts. It refers to a calculation based on the average number of months the insured is projected to live due to medical history and mortality factors (an arithmetic mean).

Life Settlement Contract establishes the terms under which the life settlement provider will pay compensation to the policyowner, in return for the assignment, transfer, sale, or release of any portion of any of the following:

- The death benefit;
- Policy ownership;
- Any beneficial interest; or
- Interest in a trust or any other entity that owns the policy.

A life settlement contract also includes a premium finance loan that is made on or before the date of issuance of the policy if the loan proceeds are not used solely to pay premiums for the policy, and/or if the owner receives a guarantee of the future life settlement value of the policy.

The following **would not constitute** a life settlement contract:

- A policy loan issued by a life insurance company;
- A loan made by a bank or a lender;
- A collateral assignment of a life insurance policy by the owner;
- An agreement between closely related parties (by blood or by law);
- A bone fide business succession arrangement;
- Employer-owned life insurance on key employees;
- An agreement between a service recipient and a service provider;
- Any other form specified by the state Department of Insurance.

Life Settlement Broker is a person who, for *compensation*, solicits, negotiates, or offers to negotiate a life settlement contract. Life settlement brokers represent only the policyowners, and have a fiduciary duty to the owners to act according to their instructions and in their best interest.

This does not include a licensed life settlement provider or its representative, an attorney, an accountant, or a financial planner. This category includes persons who would not receive a commission upon completion of a life settlement contract, but charge a fee for their services, whether or not ownership of the policy is transferred.

Life Settlement Provider is a person (other than the owner) who enters into a life settlement contract with the owner.

Disclosure

According to the disclosure regulations for life settlement brokers and providers, no later than the date the life settlement contract is signed, brokers and providers must give the owner a separate document which *clearly* lists all the required disclosures. This document must be signed by the owner and the life settlement provider. The required disclosures are explained below.

To help the **owner** understand the benefits and consequences of a life settlement transaction, at a minimum, the following information must be included in the disclosure:

- An explanation of possible alternatives, including accelerated benefits offered by the insurer;
- That some or all of the proceeds of a life settlement contract may be taxable;
- The proceeds of a life settlement contract may be subject to the claims of creditors;
- Receipt of the proceeds may adversely affect the recipient's eligibility for public assistance;
- That the proceeds will be sent to the owner within 3 business days after the life settlement provider has received acknowledgement that ownership of the policy has been transferred and the beneficiary has been designated according to the terms of the life settlement contract;
- That entering into a life settlement contract may cause other benefits under the policy, such as conversion or waiver of premium, to be forfeited by the owner;
- The total amount paid by the life settlement provider, as well as the net amount to be paid to the owner;
- The date by which the funds will be available;
- That the life settlement provider is required to furnish to the owner a consumer information booklet;
- That the insured may be contacted by either the provider or the broker to determine the insured's health status or to verify the address (the provider or broker must also disclose that the contact will be limited to once every 3 months if the insured's life expectancy is more than 1 year, and no more than once a month if the insured is expected to live 1 year or less); and
- The life settlement provider's name, business and email address, and phone number.

The life settlement broker or provider must disclose **to the insured** that the insured may be contacted by the provider, the broker, or another authorized representative for information regarding the insured's health status or for address verification. The provider or broker must also disclose that the contact will be limited to once every 3 months if the insured's life expectancy is more than one year, and no more than once a month if the insured is expected to live less than one year.

Two-Year Prohibition

Life settlements are not allowed in the first **2 years** after issuance of a life insurance policy, although exceptions may apply.

The 2-year prohibition may be waived in the following cases:

- The owner or insured is terminally or chronically ill, or physically or mentally disabled;
- The owner or insured disposes of ownership interests in a closely held corporation;
- Death of a spouse;
- Divorce;
- Retirement from full-time employment;

- The owner becomes bankrupt or insolvent; or
- Any other condition that the Department of Insurance determines to be extraordinary circumstance for the owner.

Fraudulent Acts

In connection with life settlement contracts, the following acts or omissions are considered **fraudulent life settlements acts** if committed by any person knowingly or with intent to defraud:

- Providing false material information or concealing information pertaining to any of the following:
  - An application for a life settlement contract;
  - Underwriting;
  - A claim for payment or benefit pursuant to a life settlement contract or insurance policy;
  - Premiums paid on an insurance policy;
  - Payments and changes in ownership or beneficiary made in accordance with the terms of a life settlement contract;
  - The reinstatement or conversion of an insurance policy;
  - The solicitation, offer, effectuation or sale of a life settlement contract or insurance policy;
  - The issuance of written evidence of life settlement contracts; or
  - Engaging in stranger-originated life insurance;
- Failing to disclose to the insurer that the prospective insured has undergone a life expectancy evaluation by an entity other than the insurer, in connection with the issuance of a policy;
- Employing any device, scheme or artifice to defraud in the business of life settlements.

It is **illegal** for any person to do any of the following:

- Remove, conceal, alter, or destroy the assets or records of anyone engaged in the business of life settlements;
- Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;
- Transact the business of life settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction;
- File a document containing false information or otherwise conceal information about a material fact;
- Engage in embezzlement, theft, misappropriation or conversion of moneys, funds, premiums, credits, or other property of a life settlement provider, insurer, insured, owner, insurance policyowner, or any other person engaged in the business of life settlements or insurance;

- Recklessly entering into, brokering, or otherwise dealing in a life settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy; or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the owner or the owner's agent intended to defraud the policy's issuer; or
- Attempting to commit, assisting, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this regulation.

B. Determining Amount of Personal Life Insurance

Individuals seeking to buy life insurance may need assistance trying to establish how much coverage is appropriate, based on their ability to pay the premium, serve their needs, and protect their survivors. Insurance companies have developed 2 basic approaches to help producers and buyers to determine the needed amount of protection: human life value approach and needs approach.

Human Life Value Approach

The human life value approach gives the insured an estimate of what would be lost to the family in the event of the premature death of the insured. It calculates an individual's life value by looking at the insured's wages, inflation, the number of years to retirement, and the time value of money.

Needs Approach

The needs approach is based on the predicted needs of a family after the premature death of the insured. Some of the factors considered by the needs approach are income, the amount of debt (including mortgage), investments, and other ongoing expenses.

Insurance proceeds paid in a lump-sum may be needed for any of the following expenses:

- **Costs Associated with Death (Post Mortem)** — taking into account the final medical expenses of the insured, funeral expenses, and day-to-day expenses family maintenance;
- **Debt Cancellation (as an alternative to Estate Liquidation)** — paying off debts of the insured such as home mortgage, or auto loans. (Most lenders require a collateral assignment of life insurance as a condition for a loan.);
- **Emergency Reserve Funds** — paying for unexpected expenses following the death of the insured, such as travel expenses and lodging for family members;
- **Education Funds** — paying for children's education expenses so they can remain in school, or for a surviving spouse who may need additional education or training in order to re-enter the job market;
- **Retirement Fund** — as a source of retirement income;
- **Bequests** — leaving funds to the insured's church, school, or a charity.

C. Business Uses of Life Insurance

Executive Bonuses

Executive bonus is an arrangement where the employer offers to give the employee a wage increase in the amount of the premium on a new life insurance policy on the employee. The employee owns the policy and therefore has all control. Since the employer treated the premium payment as a bonus, that amount is **tax deductible to the employer** and **income taxable to the employee**. It is assumed that if the employee were not willing to accept these conditions, the employer would not provide the benefit.

Corporate-Owned Life Insurance

A **corporate-owned life insurance** policy (COLI) is owned by the corporation and payable to the corporation. These policies are purchased on the lives of employees for whom postretirement benefits will be provided by the corporation. The corporation receives the death benefits tax-free and uses them to cover most or all of the promised postretirement benefits. Cash values will ordinarily accrue income tax free. Benefit payments made by the employer to the employee are tax deductible, but premium payments are not.

D. Classes of Life Insurance

1. Permanent vs. Term

Regarding the length of coverage, all life insurance policies fall into 2 categories: temporary and permanent protection.

Term life insurance is *temporary* life insurance provided for a specific period of time. It is also known as pure life insurance.

Permanent life insurance is a general term used to refer to various forms of whole life insurance policies that remain in effect to age 100, as long as the premium is paid. Permanent insurance provides lifetime protection, and includes a savings element (or cash value).

2. Participating vs. Nonparticipating

A **participating (mutual)** life insurance policy refers to any policy that distributes its dividends to policyowners by cash payments, reduced premiums, units of paid up insurance, a savings program, or by the purchase of term insurance. A **nonparticipating** policy does not pay dividends to the policyowners.

3. Ordinary vs. Industrial (Home Service)

Industrial or **Home Service insurance** is life insurance written on an individual basis. The following are its distinguishing features:

- Written in small amounts (usually with a face amount of less than $1,000);
- Premiums are payable on a weekly or monthly basis;

- Premiums are collected by a representative of the insurance company at the home of the insured; and
- Policies are written as nonmedical (no medical exam is required; however, medical history information is still collected).

Ordinary Life insurance is also written on an individual basis; however, it differs from Industrial Life in the following areas:

- Larger face amounts (at least $1,000);
- Premiums can be paid annually, semiannually, quarterly or monthly;
- Premiums are paid by the insured directly to the insurance company;
- A physical examination may be required to prove the applicant's insurability.

4. Group vs. Individual

Individual life insurance is written on a single life. The rate and coverage is based upon the underwriting of that individual. **Group** life insurance is written as a master policy covering the lives of more than one individual covered under the single policy. Individuals covered do not receive a policy but instead receive certificates of insurance. The rate and coverage are based upon group underwriting, with all individuals covered for the same amount and rate.

5. Fixed vs. Variable

Fixed life insurance or annuities are contracts that offer guaranteed minimum or fixed benefits that are stated in the contract. **Variable** life insurance or annuities are contracts in which the cash values accumulate based upon a specific portfolio of stocks without guarantees of performance. Variable annuities keep pace with inflation, and are determined by the value of securities backing it.

E. Factors in Premium Determination

There are three primary factors that are used in premium determination: risk (mortality - rate of death within a specific group), interest and expense.

Mortality

Mortality is the ratio of the number of deaths in a specific population over a certain amount of time versus the number of living people in that population. **Mortality tables**, used by insurers, indicate the number of individuals within a specified group of individuals (e.g. males, females, smokers, nonsmokers) starting at a certain age, who are expected to be alive at a succeeding age. In other words, these tables help the insurers predict the expectation of life and the probability of death for a given group.

Interest

Since premiums are paid before claims are incurred, insurance companies invest the premiums in an effort to earn interest on these funds (invested in bonds, stocks, mortgages, etc.). This interest is a primary factor in lowering the premium rate.

Expense

The expense factor, also known as the *loading charge,* also affects premium rates. Insurers have various operating expenses, so each premium must carry a proportionate share of these operating costs. The insurer's largest expense is the commissions paid to its agents. Other ongoing expenses include payroll, rent, and taxes.

F. Life Insurance Policy Cost Comparison Methods

To help consumers make educated decisions on purchasing life insurance, the industry developed specific methods and indexes that measure and compare the actual policy costs. These comparisons are usually included in policy illustrations. Traditional methods of comparing costs are interest-adjusted net cost method and comparative interest rate method.

The Insurance Code prescribes a method for calculating a *life insurance surrender cost index.* This method of cost comparison looks at the ultimate cost of life insurance after 10 years and 20 years. The cost index is calculated by determining the guaranteed cash surrender value, if any, in the 10th and 20th years. (For participating policies, add the accumulation dividends based on the insurer's current dividend scale to the value and assume that dividends will be retained as cash and accumulate at 5% compounded annually.) The determined amount is then divided by an interest factor of 13.20 for 10 years and 34.719 for 20 years that converts it into an equivalent level annual amount.

Life Insurance Policies

Graded Premium

Graded-premium whole life is somewhat similar to modified life in that premiums start out relatively low and then level off at a point in the future. A graded premium whole life policy typically starts with a premium that is approximately 50% or lower than the premium of a straight life policy. The premium then gradually increases each year for a period of usually 5 or 10 years, and then remains level thereafter.

Modified Life

Modified life is a type of whole life policy that charges a lower premium (similar to term rates) in the first few policy years, usually the first 3 to 5 years, and then a higher level premium for the remainder of the insured’s life. The higher subsequent premium is typically higher than a straight life premium would be for the same age and amount of coverage. These policies were developed to make the purchase of whole life insurance more attractive for individuals who, for example, are just starting out and have limited financial resources, but will be able to afford the higher premiums in the future as their income grows.

Juvenile Life

Juvenile life insurance is, as the name implies, any life insurance written on the life of a minor. A common juvenile policy is known as the “jumping juvenile” policy because the face amount increases at a predetermined age, often age 21. The face amount jumps, but the premium remains level.

Life Insurance Policy Provisions, Options, and Riders

A. Standard Provisions

Modifications

Modifications or **changes** in the policy must be endorsed on, or attached to, the policy in writing over the signature of an executive officer of the insurer. While the policyowner may request changes, only an executive officer can make the changes to the contract. Most modification clauses specifically state that no agent has the right to waive policy provisions, make alterations or agreements, or extend the time for payment of premiums.

Interest on Proceeds

If an insurer does not pay a first-party claim within a specified period of time after receipt of acceptable proof of loss, the insurer will be required to pay interest at the legal rate from the date the claim is received by the insurer. The interest rate is usually either the interest charged by the insurer on policy loans, or the rate of interest paid by the insurer on death proceeds left on deposit with the insurer.

B. Beneficiaries

Facility of Payment Clause

If the facility of payment provision is in the policy, it allows the insurer to pay a portion of the proceeds to any relative or person who has possession of the policy and appears equitably entitled to the payment. This provision is designed to facilitate payment when some doubt may exist as to who the beneficiary is and save legal expenses. It is mostly commonly found in group life, industrial, or fraternal insurance contracts.

The situations in which the facility of payment provision might be used include the following:

- The named beneficiary is a minor;
- The named beneficiary is deceased;
- The insurer did not receive death benefits claims within a specified period of time;
- Costs for the deceased insured's final medical or funeral expenses were incurred by another party, and not the beneficiary.

Spendthrift Clause

The **spendthrift clause**, when included in a life insurance policy, protects beneficiaries from the claims of their creditors. This clause applies to the benefits that are paid in fixed-period or fixed-amount installments. The beneficiary does not have the right to select a different settlement option and is not allowed to assign or borrow any of the proceeds. The spendthrift clause is designed to protect life insurance policy proceeds that have not yet been paid to a named beneficiary from the claims of the creditors of the beneficiary or policyowner.

Annuities

A. Life Contingency Options – Pure Life vs. Life with Guaranteed Minimum

The life annuity will pay a specific amount for the remainder of the annuitant's life. With **pure life**, also known as life-only or straight life, this payment ceases at the annuitant's death (no matter how soon in the annuitization period that occurs). This option **provides the highest monthly benefits** for an individual annuitant. Under this option, while the annuity payments are guaranteed for the lifetime of the annuitant, there is no guarantee that all the proceeds will be fully paid out.

Under the **life with guaranteed minimum** settlement option, if the annuitant dies before the principal amount has been paid out, the remainder of the principal amount will be refunded to the beneficiary. This option is also called **refund life**. It guarantees that the entire principal amount will be paid out.

There are two types of refund life annuities:

- **Cash refund** - when the annuitant dies, the beneficiary receives a lump-sum refund of the principal minus benefit payments already made to the annuitant. Cash refund option does not guarantee to pay any interest.
- **Installment refund** - when the annuitant dies, the beneficiary will continue to receive guaranteed installments until the entire principal amount has been paid out.

Life with period certain is another life contingency payout option. Under this option, the annuity payments are guaranteed for the *lifetime of the annuitant*, and for a *specified period of time* for the beneficiary. *For example,* a life income with a 20-year period certain option would provide the annuitant with an income while he is living (for the entire life). If, however, the annuitant dies shortly after payments begin, the payments will be continued to a beneficiary for the remainder of the period (for a total of 20 years).

Single Life vs. Multiple Life

Single life annuities cover **one life**, and annuity payments are made with reference to one life only. Contributions can be made with a single premium or on a periodic premium basis with subsequent values accumulating until the contract is annuitized.

Multiple life annuities cover **2 or more lives**. The most common multiple life annuities are joint life, and joint and survivor.

Joint Life and Joint and Survivor

Joint life is a payout arrangement where two or more annuitants receive payments until the first death among the annuitants, and then payments stop.

The **joint and survivor** arrangement is a modification of the life income option in that it guarantees an income for two recipients that neither can outlive. Although it is possible for the surviving recipient(s) to receive payments in the same amount as the first recipient to

die, most contracts provide that the surviving recipients will receive a reduced payment after the first recipient dies. Most commonly, this option is written as “joint and ½ survivor” or "joint and 2/3 survivor,” in which the surviving beneficiary receives ½ or 2/3 of what was received when both beneficiaries were alive. This option is commonly selected by a couple in retirement. As with the life income option, there is no guarantee that all the proceeds will be paid out if both beneficiaries die shortly after the installments begin.

B. Annuities Certain

In contrast with life contingency benefit payment options, *annuities certain* are **short-term annuities** that limit the amounts paid to a certain fixed period or until a certain fixed amount is liquidated.

Fixed Period

With **fixed-period installments**, the annuitant selects the time period for the benefits, and the insurer determines how much each payment will be, based on the value of the account and future earnings projections. This option pays for a specified amount of time only, whether or not the annuitant is living.

Fixed Amount

With **fixed-amount installments**, the annuitant selects how much each payment will be, and the insurer determines how long the benefits will be paid by analyzing the value of the account and future earnings. This option pays a specific amount until funds are exhausted, whether or not the annuitant is living.

C. Market Value Adjusted Annuities

A **market value** or **market value adjusted** annuity (MVA), also known as a **modified guaranteed** annuity (MGA), is a single-premium deferred annuity that allows the owner to lock in a guaranteed interest rate over a specified maturity period, anywhere between 3 to 10 years. In a MVA, penalties for a premature surrender depend upon current interest rates at the time of surrender.

Federal Tax Considerations for Life Insurance and Annuities

A. Taxation of Annuities

1. Individually Owned

A portion of each annuity benefit payment is taxable, and a portion is not. The portion that is nontaxable is the anticipated return of the principal paid in. This is known as the *cost base*. The portion that is taxable is the interest earned on the principal. This is known as the *tax base.*

The **exclusion ratio** is used to determine the annuity amounts to be excluded from taxes. The annuitant is able to recover the cost basis nontaxable. The cost basis is the principal amount, or the amount that was paid into the annuity, which is excluded from taxes. The rest of each annuity payment is interest that has been earned and is taxable.

Tax-Deferred Accumulation

The cost base represents the premium dollars that have already been taxed and will not be taxed again when withdrawn from the contract. The interest accumulated in an annuity is the tax base, but the **taxes are deferred during the accumulation period.**

Withdrawal of Interest and Principal

When money is withdrawn from the annuity *during the accumulation phase*, the amounts are taxed on a Last In, First Out basis (LIFO). Therefore, all withdrawals will be taxable until the owner's cost basis is reached. After all of the interest is received and taxed, the principal will be received with no additional tax consequences.

Taxation of Individual Retirement Annuities (IRAs)

When an annuity is used to fund a traditional IRA, distributions are fully taxable if contributions were made with pretax dollars. If there are no distributions at the required age, or if the distributions are not large enough, the penalty is **50%** of the shortfall from the required annual amount.

Lump-Sum Cash Surrenders

Cash surrender of an annuity results in immediate taxation of the interest earned.

Premature Distributions and Penalty Tax

The IRS imposes a penalty for certain premature distributions under annuity contracts. In addition to ordinary income tax that may be due, a 10% penalty is imposed on the annuity tax base for early withdrawals prior to age 59½.

Distributions at Death

If the annuity contract holder dies before the annuitization date, the interest accumulated in the annuity becomes taxable. If the beneficiary of the annuity is a spouse, however, the tax can continue to be deferred.

Values Included in Annuitant’s Estate

If the annuitant died during the **accumulation period**, the insurer is obligated to return all or a portion of the annuity cash value (values accumulated in the annuity in accordance with contract terms), which will be included in the deceased annuitant's estate. If the annuity has been paid up, and the annuitant dies during the **annuity period**, the annuity benefits will be taxable and will be included in the deceased annuitant's estate.

2. Corporate Owned

Corporate-owned annuities have different tax implications than individual annuities:

- Growth in the annuity is **not** tax deferred;
- Interest income is **taxed** annually unless the corporation owns a group annuity for its employees and each employee receives a certificate of participation.

B. Section 1035 Exchange

In accordance with Section 1035 of the Internal Revenue Code, certain exchanges of life insurance policies and annuities may occur as nontaxable exchanges. When a policyowner exchanges a cash value life insurance policy for another cash value life insurance policy, or a cash value life policy for an annuity, or an annuity for an annuity, the policies or annuities **must be on the same life**. There will be no income tax on these transactions.

The following are allowable exchanges:

- A life insurance policy for another life insurance policy, an endowment contract, or an annuity contract;
- An endowment contract for another endowment contract or an annuity contract; or
- An annuity contract for another annuity contract.

Note that a policyowner may not exchange funds from an annuity into a cash value life policy. Nor would term life be used in a 1035 Exchange since it has no cash value. The key is that the exchange may not be from a less tax-advantaged contract to a more tax-advantaged contract. *"Same to same"* is acceptable.

HEALTH ONLY

Health Insurance Basics

A. Principal Types of Losses and Benefits

Loss of Income from Disability

Loss of income caused by accident and/or sickness causing an insured the inability to work and earn income is covered under disability income policies or coverages. Disability income insurance is a valued contract or stated amount that pays weekly or monthly benefits due to an injury or sickness. Benefits may be determined by the insured's past earnings and may be limited to a percentage of that income.

Medical Expense

A medical expense contract covers many of the expenses one incurs from an accident or sickness, such as a physician or hospital expense. Expenses may be paid directly to the insured, and the insured would be responsible for paying the medical expenses. This type of benefit payment is called **reimbursement**. If expenses are paid on a scheduled basis, the insurance company will refer to a list determining the cost of the treatment, and it will only pay to a certain amount. If a person were covered as a dependent under their spouse's group insurance, payment of medical expenses would be coordinated.

B. Classes of Health Insurance Policies

Health insurance is a generic term encompassing several types of insurance contracts which, though related, are designed to protect against different risks.

There are two separate types of insurance included in the generic term *health insurance*. One type provides coverage for expenses related to health care, and the second is designed to provide payments for loss of income. The terminology used to reference health insurance varies from state to state as well as from company to company. The health insurance policy that is designed to provide periodic payments when an insured is unable to work because of sickness or injury is referred to as **disability income insurance**.

Individual vs. Group

Most health insurance is written on a group basis from one's employer. Individual coverage may be available for a family, but it would be medically underwritten.

Individual health insurance policies are underwritten to cover the applicant, their spouse and family. Many of the factors considered in life insurance underwriting apply. However, unlike life insurance where there can be only one death claim per insured, in health insurance, multiple claims per insured is the rule rather than the exception. For this reason, underwriting and classification of risk is extremely important from an insurance company standpoint.

The three most important underwriting factors considered in accepting or classifying health insurance applicants are as follows:

1. Physical condition of the applicant and other insureds;
2. Moral and morale hazards; and
3. Occupation.

From a consumer's standpoint, as important as the coverage provided, the right to continue the policy is extremely important, particularly if he/she has become uninsurable. While nearly all states have adopted the NAIC model law for uniform mandatory provisions, there are still more variables in individual health insurance policies than other types of policies.

Group health insurance underwriting varies in important particulars from that of individual health insurance. While the purpose remains the same, evaluation of the inherent hazard and assignment of the appropriate class and premium rate, the techniques and standards for evaluation are decidedly different.

The group underwriter has the responsibility not only of deciding whether and on what basis the group may be insured, but also of drawing the contract in such a way as to prevent adverse selection against the insurer by individuals eligible for coverage. Few applications for group health insurance are rejected if the applicant complies with any applicable statutory definition of a group eligible for this type of coverage. In part, this is because the underwriter may adjust the coverage and requirements necessary to afford protection to the insured. The underwriter's attitude toward group risks can be less restrictive than with individual policies, because the group policies are subject to annual re-evaluation on the anniversary date. Remedial measures may be taken if the initial evaluation proved to be incorrect.

Private vs. Government

Private insurance companies provide the large portion of all individual and group health insurance. The federal government, however, provides coverage for some disabled individuals and those over age 65 in the form of Medicare and Medicaid. Medicaid offers assistance as both a federal- and state-sponsored program. The federal government also offers disability insurance protection through the Social Security system.

Limited vs. Comprehensive

Limited health insurance policies only cover specific accidents or diseases. A **comprehensive** plan would cover all sickness or accidents that are not specifically excluded.

C. Limited Policies

Credit Disability

A credit disability policy is issued only to those in debt to a specific creditor. In case of the borrower's disability, payments to the creditor will be made on the loan until the disabled borrower is able to return to work.

Prescription Drugs

Prescription drug coverage is usually an optional benefit under a group medical policy. Generally, the insured pays a copayment amount (like $10) and the insurance company pays the balance. There are generally limitations on quantities that one can purchase at one time (such as 30-day supply).

Required Notice to Insured

To make sure that the insured is aware that the policy's benefits are limited, the insurance company must, by law, plainly state the **limited policy notice** on the first page of the policy, "THIS IS A LIMITED POLICY."

D. Common Exclusions from Coverage

The following losses are typically **not covered** in individual or group medical expense policies:

- **War or act of war** injuries or sicknesses; active military duty may be also excluded from coverage;
- **Intentionally self-inflicted injuries**;
- **Elective cosmetic surgery**; however, if treatment is required to correct a condition due to an accident or a birth defect, or is medically necessary, then coverage may be available;
- **Experimental/investigation procedures**;
- **Conditions covered by workers compensation** if they are covered under workers compensation laws or other legislation;

- **Government plans:** health insurance policies exclude expenses either paid or eligible for payment under Medicare or other federal, state, or local medical expense program;
- **Participation in criminal activity:** if a person is injured while committing an illegal act, health insurance will not cover the expense of the injury;
- **Injuries resulting from drug or alcohol intoxication** (unless administered by a physician).

E. Field Underwriting

In health insurance, **field underwriting** is far more important than in life insurance. The basic purpose of health insurance underwriting is to minimize the problem of adverse selection. Adverse selection involves the fact that those most likely to have claims are those who are most likely to seek insurance. An insurance company that has sound underwriting guidelines will avoid adverse selection more often than not. Note that the **specific underwriting requirements will vary by insurer.**

Moral hazard is a significant factor in health insurance underwriting because of the possibility of malingering, and it is the agent, not the home office underwriter, who actually has personal contact with the applicant. It is the responsibility of the agent to ask the applicant questions clearly and precisely and to record the answers accurately.

A producer's function as the field underwriter is to gather credible information from an applicant that would assist the underwriter in screening marginal or unacceptable risks before taking an application for an insurance policy.

Disclosure of Information about Individuals

An insurance company or an agent cannot disclose any personal or privileged information about an individual unless any of the following occurs:

- A written authorization by the individual dated and signed within the past 12 months has been provided;
- The information is being provided to all of the following:
    - An insurance regulatory authority or law enforcement agency, pursuant to the law;
    - An affiliate for an audit, but no further disclosure is to be made;
    - A group policyholder for the purpose of reporting claims experience;
    - To an insurance company or self-insured plan for coordination of benefits;
    - A lien holder, mortgagee, assignee or other persons having a legal or beneficial interest in a policy of insurance.

Common Situations for Errors and Omissions

At any time during the sales process there can be a misunderstanding or misrepresentation that could lead to legal action being taken by the insured. Agents should document everything: interviews, phone conversations, requests for information, etc. The **sales interview and the policy delivery** are the most common occasions for errors and

omissions (E&O) situations to occur that may result in providing inadequate coverage or failure to maintain and service coverage.

Disability Income and Related Insurance

Disability income benefits are limited to a percentage of earned income. The insurer wants a claimant to have a financial incentive to return to work. A person becomes eligible for regular disability benefits when they meet the insurance company's definition of disability due to either a sickness or an injury. This definition of disability does vary from company to company. It is important for the applicant and the producer to be fully aware of this important benefit trigger.

A. Qualifying for Disability Benefits

Inability to Perform Duties

To pay benefits, a disability income policy will require for the insured to not be able to perform the duties of his or her occupation. The benefits will also depend on the definition of disability chosen for the policy.

Own Occupation

An *own occupation* policy will provide benefits when the insured is unable to perform any duties of his/her own occupation because of sickness or accident.

This definition is usually limited to the first 24 months after a loss. It allows insureds (claimants) to receive benefits if, because of disablement, they cannot perform the duties of their normal occupation even though they might be able to earn income from a different occupation. After 24 months, if the insured is still unable to perform the duties of his or her own occupation, the definition of disability narrows to mean the inability to perform **any occupation** for which the insured is reasonably suited by education, training, or experience. This is a dramatic reduction in the insurer's liability because it is very likely that claimants can find something they can do for financial gain. The “own occ” definition is generally used for highly trained, skilled occupations such as surgeons, trial attorneys, etc.

Any Occupation

A policy that has an "any occupation" provision will only provide benefits when the insured is unable to perform any of the duties of the occupation for which they are suited by reason of education, training, or experience. "Own occupation" is the more liberal definition and therefore provides a better benefit for the insured.

Although some companies still utilize the two-tier approach by combining both definitions in a single disability income policy, from an underwriting standpoint, it is much easier for an insurance company to justify the "any occupation" definition when agreeing to issue a policy.

Pure Loss of Income (Income Replacement Contracts)

Income replacement contracts are policies which replace a certain percentage of the insured's income lost due to a covered accident or sickness, without first requiring a period

of total disability. These types of plans have lower premium costs than traditional disability policies because they take into consideration other sources of income, including income from part-time work, other disability income policies and workers compensation benefits.

Typically, these contracts are written in accordance with the "any occupation" definition for disability. Many insurers are utilizing this approach to underwriting individual disability income coverage since it minimizes the overinsurance and malingering aspects of a traditional noncancellable, "own occupation to age 65" policies.

B. Individual Disability Income Insurance

An individual Disability Income policy is applied for and paid for by the individual rather than through the employer as for group disability income. Individual Disability Income premiums are paid with after-tax dollars, and benefits are not income taxable.

Basic Total Disability Plan

A **total disability** plan protects the family or an individual against the economic loss that comes with the total disability of the wage earner.

Most often, benefits are paid monthly, but could be paid weekly in some policies. The amount of the benefit is stated in the policy and is usually limited to a percentage of one's income at the time of application to prevent overinsurance.

Coordination with Social Insurance and Workers Compensation Benefits

In order to avoid overinsurance, the insurance companies have several options to work with Social Security benefits.

Some insurance companies offer the **Additional Monthly Benefit** rider in the approximate amount that Social Security would pay. The benefit only is provided for one year. It is then anticipated that Social Security benefits would commence at the end of one year.

C. Other Provisions Affecting Income Benefits

Insurance companies offer other riders, which can affect the income benefit in the disability income policy.

Cost of Living (COLA) Rider

The purchasing power of disability benefits can be eroded by inflation. The cost of living adjustment (COLA) rider will help protect against inflation. Under this rider the insured's monthly benefit will be increased automatically, once claim payments have begun. Generally the first increase would be at the end of one year to be followed by annual increases for as long as the insured remains on the claim. Some of these riders provide for compound interest adjustments while others provide simple interest adjustments.

Future Increase Option (FIO) Rider

Guaranteed Insurability Rider, also referred to as the *Future Increase Option*, allows an insured to increase the benefit level to a specific predetermined amount at certain times or on certain occasions *without proof of insurability*. The times when the benefit may be increased are generally at ages 25, 28, 31, 34, 37 and 40. An increase may also be taken at one's marriage or the birth of a child. In order to exercise this rider, the insured must qualify from an income standpoint to prevent overinsurance.

Relation of Earnings to Insurance

The **relation of earnings to insurance** provision allows the insurance company to limit the insured's benefits to his/her average income over the last 24 months. If the total monthly amount of loss-of-time benefits promised under all valid coverages exceeds the monthly earnings of the insured at the time of disability, or the average monthly earnings for the previous **2 years** (whichever is greater), the insurer will only be liable for a proportionate amount of benefits. If necessary, the benefits are reduced on a pro-rata basis.

Accidental Death and Dismemberment

A disability policy may contain an Accidental Death and Dismemberment rider which pays for accidental losses only, and is thus considered a pure form of accident insurance. The **principal sum** is paid for accidental death. This amount is usually equal the amount of coverage under the insurance contract, or the face amount. In case of accidental dismemberment or loss of sight in one eye, a **percentage** of that principal sum will be paid by the policy, also referred to as the **capital sum**. The amount of the benefit will vary according to the severity of the injury.

For example, the policy will usually pay the full principal for the loss of sight in both eyes, or two or more limbs; however, it may only pay 50% for the loss of one hand or one foot. In addition, some policies will pay double or triple indemnity, meaning the policy will pay twice or three times the face amount in the event of accidental death. Most policies will pay the accidental death benefit as long as the death is caused by the accident and occurs within a specific time, such as 60-90 days.

Rehabilitation Benefit

If the insured has been totally disabled, it is possible that rehabilitation will be necessary to help get the insured back to work, either in their old occupation or in another occupation. The rehabilitation benefit will cover a portion of the cost for the insured to enroll in a formal retraining program that will help the insured to return to work. This benefit usually offers a specified sum (several times of the monthly indemnity) to cover costs not paid by other insurance.

Medical Reimbursement Benefit (Nondisabling Injury)

This benefit provides for the payment of medical expenses incurred due to an accidental bodily injury when the insured is not disabled.

D. Refund Provisions

Some insurance companies offer an incentive for low claim usage by offering a refund under the proper conditions.

Return of Premium

The return of premium rider provides a refund of a percentage of premiums at certain times. *For example*, at the end of the tenth year, the insurance company may offer to refund 80% of the excess of premiums paid over claims.

Cash Surrender Value

The cash surrender rider creates a cash value of around 70% of the premiums paid in excess of claims. This cash value is often only available to the owner at the termination of the contract.

E. Occupational Considerations

In disability income policies, the **insured's occupation** is a critical underwriting factor. The more hazardous the applicant's occupation, the higher the premium the insurance company will charge. Professionals like attorneys and doctors pay the lowest premiums and get the superior definitions of disability. More hazardous occupations, like construction workers, pay higher premiums and receive poorer definitions of disability because of a greater risk of disability.

F. Policy Issuance Alternatives

If the underwriter feels that applicant is too great of a risk, the applicant could be declined. However, if the risk is more than standard but less than a decline, the underwriter could offer the policy on a rated-up basis or issue the contract with an exclusion rider. If the policy is rated up, the premium will be increased. If a policy contains an exclusion rider, then the loss related to that exclusion would not be covered.

G. Social Security Disability

Social Security, also referred to as **Old Age Survivors Disability Insurance** — OASDI, is a Federal program enacted in 1935, which is designed to provide protection for eligible workers and their dependents against financial loss due to old age, disability, or death. With a few exceptions, almost all individuals are covered by Social Security. In some aspects, Social Security plays a role of federal life and health insurance, which is important to consider when determining an individual's needs for life insurance.

Qualification for Disability Benefits

Social Security uses the Quarter of Coverage (QC) system to determine whether or not an individual is qualified for Social Security benefits. The type and amount of benefits are determined by the amount of **credits** or **QCs** a worker has earned. Anyone working in jobs covered by Social Security or operating his/her own business may earn up to a maximum of 4 credits for each year of work.

The term **fully insured** refers to someone who has earned **40 quarters** of coverage (the equivalent of 10 years of work), and is therefore entitled to receive Social Security retirement, Medicare, and survivor benefits. An individual can attain a **currently insured** status (or partially insured), and by that qualify for certain benefits if he or she has earned **6 credits** (or quarters of coverage) during the 13-quarter period *ending with the quarter in which the insured:*

- Dies;
- Becomes entitled to disability insurance benefits; or
- Becomes entitled to old-age insurance benefits.

For younger workers, the number of quarters required to qualify for the benefits differs by age according to a table established by Social Security.

Definition of Disability

Assuming that one qualifies for Social Security disability benefits by being *fully insured* or *partially insured*, one must then meet Social Security's definition of disability. **Disability**, under Social Security, is defined as the inability to engage in any substantially gainful activity by reason of a medically determinable physical or mental impairment that has lasted or is expected to last 12 months or result in an early death. **This definition is not as liberal as most definitions of disability found in policies marketed through insurance companies.**

Waiting Period

The waiting, or elimination period for Social Security disability benefits is **5 months**. Benefits begin at the beginning of the 6th month and are not retroactive to the beginning of the disability.

Disability Income Benefits

The amount of Social Security disability benefits is based upon the worker's Primary Insurance Amount (PIA), which is calculated from their Average Indexed Monthly Earnings over their highest 35 years. The lowest 5 years of income may be deleted from calculation.

Social Security disability benefits will continue for 3 months when a person returns to work making more than $850 per month. This is an incentive to get people back to work.

Medical Plans

A. Medical Plans Concepts

Fee-for Service Basis vs. Prepaid Basis

Medical expense plans could be **fee-for-service** where providers receive a payment for their billed charges for each service provided. **Prepaid plans** provide medical and hospital benefits in the form of service rather than dollars. In prepaid plans the providers are compensated regularly whether or not they provide service, but no additional compensation is provided when services are rendered.

Specified Coverages vs. Comprehensive Care

Specified coverage policies are those insurance policies that limit coverage to one illness or one limiting group of coverages, i.e. cancer policies, prescription drug coverage, dental plans, and other limited coverage plans. These policies are commonly written as a stand-alone individual policy or to complement a traditional fee-for-service Major Medical Expense Policy.

Comprehensive care policies are those plans that provide coverage for most types of medical expenses: a comprehensive package of health care services that typically includes preventive care, routine physicals, immunizations, outpatient services and hospitalization, such as HMOs.

Any Provider vs. Limited Choice of Providers

More traditional reimbursement type comprehensive medical expense plans allow the insured to be treated by most any qualified physician. The newer managed care type of plans limit their benefits to physicians and care centers that are on their specific list of providers.

Insureds vs. Subscribers

The participants in a plan are either considered insureds or subscribers. **Insureds** are people covered by insurance, and who usually receive health insurance benefits. **Subscribers** (also referred to as **participants or members**) are people who sign up for pre-paid health plans, such as HMOs. In an individual policy, a subscriber is a person in whose name the contract is issued; in group policies, subscriber means a person whose employment or other status (with the exception of family dependency) is the basis for eligibility for the enrollments in an HMO.

B. Cost Containment in Health Care Delivery

1. Cost-Saving Services

Cost-saving services or case-management provisions provide plans with controlled access of providers, large claim management, preventive care, hospitalization alternatives, second surgical opinions, preadmission testing, catastrophic case management, risk sharing, and providing high quality of care. Insurance companies use the services of case managers for large, ongoing claims through a process of utilization management. The case manager evaluates the appropriateness, necessity, and quality of health care, and may include prospective and concurrent review.

Preventive Care

Managed care plans encourage preventive care and living a healthier lifestyle. Annual physical exams, mammograms, and other procedures used to detect medical problems before symptoms appear can result in a considerable cost savings if a problem is detected early and treated quickly.

Hospital Outpatient Benefits

Because hospital confinement has become so costly, many plans require the patient to take advantage of outpatient services when possible.

Alternatives to Hospital Services

Alternatives to hospital care might include home health care where the patient stays at home and is visited periodically by a health professional. A home health aide that could work in conjunction with a family member may meet daily needs. Terminally ill patients may elect hospice care rather than a hospital stay. Hospice attends to the patient's daily needs and provides pain relief but attempts no curative procedures. Within cost containment, painkillers and special hospital beds are paid for, but operations or antibiotics are not.

2. Utilization Management

Utilization management consists of an evaluation of the appropriateness, necessity and quality of health care, and may include different types of reviews: prospective, retrospective, or concurrent review.

Prospective Review

Under the **prospective review** or **precertification process**, the physician can submit claim information prior to providing treatment to know in advance if the procedure is covered under the insured's plan and at what rate it will be paid.

Concurrent Review

Under the concurrent review process, the insurance company will monitor the insured's hospital stay to make sure that everything is proceeding according to schedule and that the insured will be released from the hospital as planned.

Group Health Insurance

A. Characteristics of a Group Contract

Experience Rating vs. Community Rating

Group health insurance is usually subject to **experience rating**, where the premiums are determined by the experience of this particular group as a whole. Individual policies are subject to **community rating** or pool rating, where the premium is based upon the overall claims experience of the insurance company. Experience rating helps employers with low claims experience because they get lower premiums.

B. Employment-Related Groups

Individual Employer Groups

The individual employer normally will provide insurance coverage to all full-time employees. The employer can specify within some limitations how many hours are considered full time, and whether both salaried and hourly employees will be covered. The employer can legally exclude a particular group of employees, like union or part time, from the eligible class of employees.

Multi-Employer Trusts (METs) or Welfare Arrangements (MEWAs)

A **Multiple-Employer Trust (MET)** is made up of two or more employers in *similar or related businesses* who do not qualify for group insurance on their own. Before HIPAA defined small employers, many small companies were unable to get health insurance at a reasonable cost due to the fact that there weren't enough people in the company to insure. In situations like this, several small companies banded together to create a large pool of people so that the insurance company will provide coverage. This group of employers jointly purchase a single-benefit plan to cover employees of each separate employer.

A noninsured plan may operate without the services and funds of an insurance company. Once the trust fund is established, it can pay for employees' health care expenses directly (self-funding). The trustee has charge of the funds and all financial activities occur through it. As with any self-funded program, the employer assumes legal responsibility for providing coverage, and the employee has no conversion right upon leaving the group coverage.

Multiple Employer Welfare Associations (MEWAs) can be any entity, other than a duly admitted insurer, that establishes an employee benefit plan for the purpose of offering or providing accident and sickness or death benefits to the employees of **at least 2 employers**, including self-employed individuals and their dependents.

A Multiple-Employer Welfare Arrangement (MEWA) is similar to an MET, except that MEWAs are groups of employers that pool their risks in order to *self-insure*. These groups could be sponsored by an insurance company or an independent administrator who may help a MEWA to design a plan or handle the administration. Groups can be from the same or related industries because of the Law of Large Numbers/Similar Risks.

Today, the terms have become blurred and MEWAs and METs are generally known as interchangeable plans. They are considered risky if not fully insured. Some METs/MEWAs are only partially insured, and the individuals or employers retain full responsibility for any debt if not fully insured.

Customer Groups

Creditor group, also called credit life and health insurance, is a specialized use of group life and group health insurance that covers debtors (borrowers). It protects the lending institution from losing money as the result of a borrower’s death or disability. Generally, the borrower is the premium payor but the lending institution is the beneficiary of the policy. The amount of insurance cannot exceed the amount of indebtedness.

C. Employer Group Health Insurance

Employee Eligibility

Employer group health insurance generally requires that to be eligible for coverage an employee must be a full time employee, working in a covered classification, and must be actively at work.

Under the Affordable Care Act (ACA), employers must extend coverage to all employees who work more than 30 hours per week. In addition, small and large employers may not be denied coverage for failure to satisfy the minimum participation or contribution requirements.

Annual Open Enrollment

A **30-day open-enrollment period** is available once a year to employees who reject coverage during the initial enrollment period and later wish to have coverage or to add dependent coverage. Evidence of insurability is not required during open enrollment.

Dependent Eligibility

Employer group health insurance generally requires a dependent of an employee to be

- A spouse;
- A child younger than the limiting age, including natural children of the insured, stepchildren, children legally placed for adoption, and legally adopted children;
- Disabled children who are incapable of self-support because of a physical or mental disability and are dependent upon the insured for support and maintenance.

Most insurers cover domestic or same-sex partners whether or not a state has a domestic partner or civil union law.

Change of Insurance Companies or Loss of Coverage

Coinsurance and deductibles may be carried over from the old plan to the new plan. The purpose of coinsurance and deductible carryover provisions is to credit expenses incurred so as to not penalize the insured.

No-Loss No-Gain

No-loss/no-gain statutes involve the theory of indemnification and the concept of placing the insured in the same economic position after a loss as the insured was in prior to a loss. When changing health insurance, benefits must be paid for ongoing claims regardless of pre-existing conditions.

D. Marketing Considerations

Advertising

Health insurance advertising must be truthful and not misleading. Words and phrases may not be used if their meaning is clear only by implication or familiarity with insurance terminology.

In advertisements of benefits payable, losses covered, and premiums payable, words, phrases or illustrations cannot be used in a manner which misleads, or has the tendency or capacity to deceive, concerning any policy benefit payable, loss covered, or premium payable. Advertisements must be sufficiently complete and clear as to avoid deception or the capacity or tendency to deceive.

Regulatory Jurisdiction and Place of Delivery

Group insurance can often provide coverage for employees in more than one state. The question then becomes which state law has jurisdiction over the policy. Generally speaking, the state in which the coverage was delivered would have jurisdiction. Most state laws governing group insurance say that multi-state policies are acceptable if the policy is approved by the issuing state, written in substantial compliance with the laws of the delivery state, and if the laws governing group insurance are substantially similar between the issuing state and the delivery state.

Dental Insurance

A. Types of Dental Treatment

Restorative care means treatments, which restore functional use to natural teeth such as fillings or crowns.

Oral surgery means operative treatment of the mouth such as extractions of teeth and related surgical treatment.

Endodontics means treatment of the dental pulp within natural teeth, such as a root canal.

Periodontics means the treatment of the surrounding and supporting tissue of the teeth such as treatment for gum disease.

Prosthodontics means the replacement of missing teeth with artificial devices like bridgework or dentures.

Orthodontics means treatment of natural teeth to prevent and/or correct dental anomalies with braces or appliances.

B. Indemnity Plans

There are three different types of indemnity plans available, including

- Scheduled or basic plan;
- Comprehensive or nonscheduled plan; and
- Combination of both basic and comprehensive plans.

Choice of Providers

Some dental plans limit the insured's choices of providers, but others simply limit the benefits to any qualified practitioner.

Scheduled vs. Nonscheduled Plans

Basic or **scheduled plans** pay benefits from a list of procedures up to the amount shown in the schedule. Most plans provide first-dollar benefits without coinsurance or deductibles. Maximum benefits are often lower than the usual and customary charges of dentists who force the insured to bear a portion of the cost.

With **nonscheduled plans**, benefits are paid on a reasonable and customary basis and are subject to deductibles and coinsurance. Services are usually divided into three broad benefit categories: diagnostic/preventive services, basic services, and major services.

Benefit Categories

Dental insurance plans typically provide coverage for the following types of treatment.

Diagnostic/Preventive Services generally are not subject to coinsurance or deductibles.

Basic Services such as fillings, oral surgery, periodontics, and endodontics may require the insured to pay a deductible or 20% of the balance (the insurer would pay the other 80%).

Major Services, such as inlays, crowns, dentures and orthodontics, could either have large deductibles or pay around 50% for services provided.

Deductibles and Coinsurance

Most dental plans have a deductible amount such as $25, $50, or $100, which must be met each calendar year. Generally, the deductible does not apply to preventive care like cleaning and routine examinations.

Stand-Alone Dental Plans vs. Combination Plans

The Exchange may offer a **stand-alone dental plan** offering a limited scope of dental benefits as long as the plan meets all the appropriate requirements, covers at least the pediatric dental essential health benefit, and meets a Qualified Health Plan (QHP) certification standards.

Combination plans combine features of both the basic and comprehensive plans. They generally cover diagnostic and preventive services on a usual and customary basis but still use a fee schedule for other dental services.

Exclusions and Limitations

Dental plans typically **exclude** cosmetic services (unless required by an accident), replacement of lost dentures, duplicate dentures, oral hygiene instruction, occupational injuries covered by workers compensation, or services provided by government agencies.

To help keep costs down, dental plans provide more limitations than deductibles and copayments. Most plans provide for **calendar year maximum benefits** and **lifetime maximum benefits**. Routine exams and cleaning are generally limited to once every 6 months, full mouth x-rays to once every 2 to 3 years, and replacement of dentures to once every 5 years.

Predetermination of Benefits

The predetermination of benefits (precertification or prior authorization) clause is found in most dental plans. This service, although generally not mandatory, will allow the insured and the dentist to know in advance what benefits will be paid.

Insurance for Senior Citizens and Special Needs Individuals

A. Other Options for Individuals with Medicare – Employer Group Health Plans

Disabled Employees

The Omnibus Budget Reconciliation Act of 1990 requires that large group health plans (100 employees or more) must provide primary coverage for disabled individuals under age 65 who are not retired.

Employee with Kidney Failure

The Omnibus Budget Reconciliation Act of 1990 as amended by the Balanced Budget Act of 1997 requires the employer health plan to provide primary coverage for **30 months** for individuals with end-stage renal (kidney) disease before Medicare becomes primary.

Individuals Age 65 and Older

If an employee is still employed upon reaching age 65, federal laws require allowing the employee to remain on the group health insurance rolls and to defer Medicare coverage until retirement. The employee has the right to reject the company's plan and elect Medicare but the company can offer no incentives for switching to Medicare.

If an employee remains on the group plan and signs up for Medicare, in groups of less than 20 employees, Medicare will be the primary coverage. In groups of 20 or more, the group coverage will be primary over Medicare.

B. LTC Underwriting Considerations

All applications for long-term care insurance policies, except those that cannot be denied based on answers in the application, must contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

Before a long-term care policy will be issued to an applicant age 80 or older, the insurer must obtain the following:

- A report of a physical examination;
- An assessment of functional capacity;
- An attending physician's statement;
- Copies of medical records.