PREPARING PEOPLE TO PASS

XCEL TESTING SOLUTIONS

LIFE INSURANCE ANNUITIES, and INSURANCE LAWS

Pre-licensing Education – Life Insurance and Annuities

Basic Principles of Life and Health Insurance and Annuities

➢ TYPES OF INSURANCE COMPANIES

Commercial Insurers (also known as **private insurance companies**) are in the business of selling insurance for a profit. Commercial insurers offer many lines of insurance. Some sell primarily life insurance and annuities, while other sell accident and health insurance, or property and casualty insurance. An insurance company selling more than one line of insurance is known as a **Multi-line insurer.** Commercial insurance is divided into two main groups: stock and mutual insurers.

Stock Companies are organized and incorporated under state laws for the purpose of making a profit for its stockholders (shareholders). Traditionally, stock insurers are called **nonparticipating insurers** because policyholders do not participate in receiving dividends or electing the board of directors, unless they are also a stockholder of the company. When declared, stock dividends are paid to stockholders. In a stock company, the directors and officers are responsible to the stockholders. Transformation of a stock insurer into a mutual insurer is termed mutualization, and the reverse is termed demutualization. Dividends from a stock insurer subject to taxation because they are considered profit.

Mutual Companies are owned by their policyholders. Mutual insurers are known as **Participating Insurers** because policyholders PARTICIPATE in receiving dividends and electing the board of directors. When declared, mutual company dividends are paid to the policyholders**.** Dividends from a mutual insurer are not subject to taxation because the dividends are considered to be a return of premium. The only exception is if the policyowner chooses to let the dividends sit and collect interest. In this case, only the accumulated interest would be taxable.

If a company operates as both a **PARTICIPATING** and **NONPARTICIPATING** insurer they are known as a **MIXED insurer.** DIVIDENDS can NEVER be guaranteed regardless of the type of company offering them.

Strong Assessment Mutual Companies are classified by the way the charge premium.

1. **A pure assessment mutual company**, operates based on loss-sharing by group members. No premium is payable in advance. Instead, each member is assessed an individual portion of losses that occur.
2. **An advance premium assessment mutual**, charges a premium at the beginning of the policy period. If the original premiums exceed the operating expenses and losses, the surplus is returned to the policyholders as dividends. However, if total premiums are not enough to meet losses, additional assessments are levied against the members. Normally, the amount of assessment that may be levied is limited either by state law or simply as a provision in the insurer's by-laws.

Fraternal benefit societies are special types of mutual companies, nonprofit religious, ethnic or charitable organizations that provide insurance solely to their members. Fraternal must be formed for reasons other than obtaining insurance. *An example of fraternal societies is Knights of Columbus.*

Risk retention groups are mutual companies formed by a group of people in the same industry or profession. *Examples would be pharmacists, dentists, and engineers.*

Service Providers offer benefits to subscribers in return for the payment of a premium. These services are packaged into various plans, and those who purchase the plans are known as subscribers. *Examples of service providers are Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO).*

Reciprocal insurers are unincorporated groups of individual members that provide insurance for other members through indemnity contracts. Each member acts as both insurer and insured and are managed by Attorney in Fact.

Reinsurers make arrangements with other insurance companies to transfer a portion of their risk to the reinsurer. The company transferring the risk is called the **Ceding Company** and the company assuming the risk is the **Reinsurer.**

Captive Insurer is an insurer established and owned by the parent company to insure the parent company's loss exposure.

Home Service Insurers (also known as **industrial insurance**), is sold by home service or **debit** life insurance companies. Face amounts are small; usually $1,000 to $2,000 and premiums are paid weekly.

Government Insurance: Federal and state government are also insurers. They provide social insurance programs, to protect against universal risks by redistributing income to help people who cannot afford the cost of incurring such losses themselves. These programs have far reaching effects and millions of people depend on them. Types of Government Insurance include:

- **Social Security** (**O**ld **A**ge **S**urvivor **D**isability **I**nsurance **OASDI** – Provides income benefits for the elderly (retirement), survivors of those who died young (young child of a deceased parent), and those qualifying for federal disability.
- **Medicare -** Health insurance to CARE for the elderly
- **Medicaid -** Health insurance to AID the financially needy.
- **S.G.L.I.** and **V.G.L.I** (Serviceman's or Veteran's Group Life Insurance: life insurance for active and retired members of the military)
- **Tri-Care** (health insurance for members of the military and their family)

Self-Insurers retain risks and must have a large number of similar risks and enough capital to pay claims. However, they may save money if the loss experience is lower than the expected costs. Self-insurers are not a method of transferring risk, rather self-insurers establish their own self-funded plan to cover potential losses. A **Self-funded plan** is a plan in which an employer pays insurance benefits from a fund derived from the employer's current revenues

Lloyd's of London is not an insurance company. Members of the association form syndicates to underwrite and issue insurance- like coverage. This is a group of investors who share in unusual risk.

➢ HOW INSURANCE IS SOLD

Distribution Systems are the ways insurance products are marketed and sold to the public. Insurance can be purchased through licensed insurance producers, who are either agents or brokers, or through a number of other ways. Agents are either captive/career agents or independent agents. Captive agents work for only one insurer. Independent agents work for themselves or for several insurers non- exclusively.

Career Agency System: With the career agency system commercial insurers establish offices in certain locations. Career agents are recruited to work at these locations. A general agent hires and trains new producers and supervises a number of other producers. All producers under the career agency system are captive agents and employees of the insurer.

Personal Producing General Agency System: With the personal producing general agency (PPGA) system, agents work for an independent agency selling policies from several insurance companies. Unlike the career agency system, agents are not employees of the insurance company. Instead, they work for the PPGA. Furthermore, personal producing general agents primarily sell insurance, instead of recruiting and training new agents as in the career agency system.

Independent Agency System (American Agency System): Independent agents represent a number of insurance companies under separate contractual agreements. They may also work for themselves or under other insurance agents. Independent insurance agents have control and ownership over their clients' accounts. This means they may place clients' business with

a different insurer when policies are up for renewal. Independent insurance agents earn commissions on the sales they make and overrides on sales made by agents they manage.

Managerial System: With the managerial system, branch offices are established in several locations.
Instead of a general agent running the agency, a salaried branch manager is employed by the insurer. The branch manager supervises agents working out of that branch office. The insurer pays the branch manager's salary and pays him a bonus based on the amount and type of insurance sold and number of new agents hired.

Mass Marketing: Another way to sell insurance is through mass marketing methods. Direct selling (or direct mail) is a mass marketing method where agents are not used. Instead, policies are marketed and sold through television and radio advertisements, print sources found in newspapers and magazines, by mail, in vending machines, and over the internet.

- **INDUSTRY OVERSIGHT AND REGULATION**

The insurance industry is primarily regulated on a state-by-state basis with minimal federal oversight. The primary purpose of this regulation is to promote public welfare and provide consumer protection and ensure fair trade practices, contracts and prices. Key historical events that have shaped the current regulation include:

- **1869 Paul v. Virginia:** the U.S. Supreme Court ruled that insurance transactions crossing state lines are not interstate commerce.

- **1905 The Armstrong Investigation Act** gave the authority to the states to regulate insurance.

- **1944 United States v. South-Eastern Underwriters Association** ruled that insurance transactions crossing state lines are interstate commerce and are subject to federal regulation. Thus, many federal laws were conflicting with existing state laws. However, this decision did not affect the power of states to regulate insurance.

- **1945 The McCarran Ferguson Act** states that while the federal government has authority to regulate the insurance industry, it would not exercise its right if the insurance industry was regulated effectively and adequately on the state level. Under the McCarran-Ferguson Act, the minimum penalty of a producer who has obtained personal information about a client without having a legitimate reason to do so is a fine of $10,000.

- **1970 Fair Credit Reporting Act:** provides individuals privacy protection and fair and accurate credit reporting. Insurance companies are required to notify applicants if a credit check will be made on them. Under the Fair Credit Reporting Act, the maximum penalty of a producer who has obtained Consumer Information Reports under false pretenses is a fine of $5,000.

- **1999 Gramm-Leach-Bliley Act (Financial Services Modernization Act)**: This law repealed the Glass-Steagall Act; this allows Banks, Retail Brokerages and Insurance companies to enter each other's line of business.

- **2001 USA PATRIOT ACT (U**niting and **S**trengthening **A**merica by **P**roviding **A**ppropriate **T**ools **R**equired to **I**ntercept and **O**bstruct **T**errorism Act**):** as it relates to the insurance industry, is designed to detect and deter terrorists and their funding by imposing anti-money laundering requirements on brokerage firms and financial institutions.

- **2003 National Do Not Call Registry:** Insurance calls are not exempt from the no not call registry.

- **2010 Patient Protection and Affordable Care Act (PPACA):** often shortened to the **Affordable Care Act** (**ACA**), represents one of the most significant regulatory overhauls and expansions of coverage in U.S. history.

The **National Association of Insurance Commissioners (NAIC)** is an organization composed of insurance commissioners from all 50 states, the District of Columbia and the 4 US territories. They are responsible for recommending appropriate laws and regulations. They are responsible for the creation of the **Advertising Code** and the **Unfair Trade Practices Act,** and the Medicare Supplement Insurance Minimum Standards Model Act. The NAIC has four broad objectives:

1. To encourage uniformity in state insurance laws and regulations
2. To assist in the administration of those laws and regulations by promoting efficiency
3. To protect the interest of policyowners and consumers
4. To preserve state regulation of the insurance business

Advertising Code: the code specifies certain words and phrases that are considered misleading and are not to be used in advertising of any kind.

Unfair Trade Practices Act: gives chief financial officer the power to investigate insurance companies and producers to impose penalties. In addition to that, the act gives officers the authority to seek a court injunction to restrain insurers from using any methods believed to be unfair.

NAIFA (National Association of Insurance and Financial Advisors) **and NAHU** (National Association of Health Underwriters): Members of these organizations are life and health agents dedicated to supporting the industry and advancing the quality of service provided by insurance professionals. *These organizations created a Code of Ethics detailing the expectations of agents in their duties toward clients.*

To sell insurance, each state requires high level of professionalism and ethics. Some of these standards and ethics are:

- Selling to needs: agents must first determine the consumers' needs then determine which policy fits their needs best.
- Suitability of recommended products: an ethical agent must be able to assess the correlation between a recommended product and the consumer's needs.
- Full and accurate disclosure: an ethical agent must inform consumers of the benefits and limitations of recommended products. Recommendations must be accurate, complete and clear.
- Documentation: an ethical agent must document each client's meeting and transaction.
- Client Services: an ethical agent must know that a sale does not mark the end of the relationship, but rather the beginning of the relationship. Therefore, routine follow-up calls are recommended.
- **Buyer's Guide:** each state requires agents to deliver a buyer's guide to consumers that explain various types of life insurance products and other information on the recommended policy, such as premiums, dividends, and benefit amounts.
- **Policy Summary:** help consumers evaluate the suitability of the recommended product.

Reserves: are the accounting measurement of an insurer's future obligations to its policyholders. They are classified as liabilities on the insurance company's accounting statements since they must be settled at a future date. Reserves are set aside by an insurance company and designated for the payment of future claims.

Liquidity: An insurer's ability to make unpredictable payouts to policyowners

Guaranty Associations are established by all states to support insurers and protect consumers in case an insurer becomes insolvent. State life and health guaranty associations provide a safety net for all member life, health and annuities insurers in a particular state. Guaranty associations protect insureds in the event of insurer insolvency, or inability to pay claims up to a certain limit.

Independent Rating Services are credit rating agencies that rate or "grade" the financial strength and stability of insurers based on claims, reserves, and company profits. The nationally recognized statistical rating organizations that rate insurers are **A. M. Best, Moody's, Standard and Poor's, and Fitch Ratings.** Each rating service has its own rating system, but most use an A to F letter grading scheme.

Nature of Insurance

➢ HAZARDS, PERILS, and RISK

Hazard: A condition or situation that creates or increases a chance of loss. For example, icy roads, driving while intoxicated, improperly stored toxic waste. Types of Hazards include:

- **Physical** – Poor health, overweight, blind.
- **Moral** – Dishonesty, drugs, alcohol abuse.
- **Morale** – Careless attitude – reckless driving, jumping off a cliff, stealing, racing motorcycles, carefree, careless lifestyle. This attitude causes an indifference to loss.

Loss: is the unintentional decrease in the value of an asset due to a peril.

Peril: an immediate, specific event which causes loss, such as an earthquake or tornado. Perils can also be referred to as the accident itself.

Risk: the potential for loss

Speculative Risk: is a risk that presents both the chance for loss or gain. Gambling is an example. Speculative risks are not insurable.

Pure Risk: is the only insurable risk and present a potential for loss only, such as injury, illness, and death.

ELEMENTS OF INSURABLE RISK

- **Loss must be due to chance** – Causeless, outside the insured's control.
- **Loss must be definite and measurable** – Time, place, amount, and when payable.
- **Loss must be predictable** – Statistically able to estimate the average frequency and severity.
- **Loss cannot be catastrophic** – Must be reasonable, 1 trillion-dollar policy is not reasonable.
- **Loss exposure to be insured must be large** – Ideally, common enough that the insurer can pool many homogeneous, or similar, exposure units (**law of large numbers**).
- **Loss must be randomly selected** – Fair proportion of good and poor risks (**adverse selection**).

Law of Large Numbers: The larger the amount of exposures that are combined into a group, the more certainty there is to the amount of loss incurred in any given period. The Law of Large Numbers allows:

- Prediction of individual and group losses based on past experience
- An increased degree of accuracy in predicting losses in large groups

Homogeneous exposure units: are similar objects of insurance that are exposed to the same group of perils. For example, insuring a large number of homes in the same geographical area against hail damage.

Adverse Selection: Insurers must minimize adverse selection, which is defined as the tendency for poorer than average risks to seek out insurance. **For example,** a person who takes 12 prescriptions is a poor risk. If an insurer cannot compensate poor risks with better than average risks, then its loss experience will increase and its ability to pay claims may be compromised.

Risk Management: is the process of analyzing exposures that create risk and designing programs to handle them.

Treatment of Risk – how people deal with risk

- **Avoidance** – Avoid the risk all together. For example, you can avoid the risk of getting injured in a car accident by never leaving the house.
- **Reduction** – Take precautions; minimizing severity of a potential loss. For example, you can reduce the risk of getting injured in a car accident by taking public transportation.
- **Retention (Self Insure**) – accepting a risk and confronting it if it occurs. For example, you would retain the risk of getting injured in a car accident by driving without insurance.
- **Transfer (Transference)** – Make someone else responsible for a loss. For example, buying auto insurance transfers the cost associated with a car accident from the driver to the insurance company. Buying Insurance is the best way to transfer risk.
- **Risk Pooling (Loss sharing):** When a large group of people spread a risk for a small certain cost. It transfers risk from an individual to a group. An example of **Risk sharing** would be, doctors pooling their money to cover malpractice exposures

Reinsurance: Insurers deal with catastrophic loss through reinsurance, which is defined as a contractual arrangement that transfers exposure from one insurer to another insurer.

Principle of Indemnity: involves making an insured whole by restoring them to the same condition as before a loss.

➢ ECONOMIC BASIS OF INSURANCE

Human Life Value Approach: A method of determining the financial value of a person's life based on computing the current value of a person's future earnings for a certain period of time. For example, if the main income earner of the family makes $50,000 a year and the family would like to make sure they are protected for 10 years in the event something happens to the main income earner. $50,000 (current income) X 10 years (protection) = $500,000 insurance policy.

Needs Based Value Approach: A method of determining a person's financial value based on the amount of money needed for current and future expenses. These expenses include final expenses, spouse's income, mortgage, college education, retirement, charity donations, etc. For example, a family would like to ensure they can take care of 5 years of annual expenses if something were to happen to the main income earner, and they have an average of $60,000 worth of expenses per year. $60,000 (expenses) X 5 years (protection) = $300,000 insurance policy.

Legal Concepts of the Insurance Contract

Insurance policies are legal contracts where a promise of benefits is exchanged for valuable consideration (Premiums). Contracts of insurance are binding and enforceable. All parties are subject to specific legal requirements.

- **Life insurance:** the insurance company agrees to pay a predetermined amount – the **face amount (**or **benefit),** in exchange for the insured's consideration **(premium)**.
- **Health insurance:** the insurance company agrees to pay a percentage of the insured's medical bills **(**or **benefit)** in exchange for consideration **(premiums**).

➢ ELEMENTS OF THE CONTRACT

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

1. Consideration: Consideration is something of value that each interested party gives to each other. The insured provides **consideration** with **payment of premium**. The insurer provides consideration by **promising to pay** the insurance benefit. The applicant says, "PLEASE CONSIDER me for insurance. Here's my initial premium, my completed application, as well as how much and how often I agree to pay."

2. Legal Purpose: An insurance contract must be legal and not in opposition of public policy. If an insurance contract has **insurable interest** and the insured has provided written consent, it has **legal purpose**. Without legal effect, the contract would be null and void. Said differently, the contract cannot be for an illegal purpose.

3. Offer and Acceptance: An **offer** is made when the applicant submits an **application and initial premium** for insurance to the insurance company. The **offer** is accepted by the insurer after it has been **approved** by the insurance company's **underwriter** and a policy is issued. If no money is given, the applicant is making an invitation. On the other hand, if an offer is answered by a counteroffer, the first offer is void.

4. Competent Parties: All parties must be of legal competence, meaning they must be of legal age, mentally capable of understanding the terms, and not influenced by drugs or alcohol**.**

➢ SPECIAL FEATURES OF INSURANCE CONTRACTS

Contract of Adhesion: Because an insurance contract has been prepared by an insurance company with no negotiation, it is considered a contract of adhesion. In a contract of adhesion there is only one author – the insurance company. Insurance carriers are also responsible for assembling the policy forms for insureds. If there is an ambiguity in the contract, the courts always favor the insured over the insurer. Under a contract of adhesion, the terms must be accepted or rejected in full. The customer must adhere to the insurer's contract without any input of their own.

Aleatory Contract: Insurance contracts are aleatory, which means there is an unequal exchange. The premiums paid by the applicant is small in relation to the amount that will be paid by the insurance company in the event of a loss. For example, Tory paid one month's premium of $50, when she died one month later, her beneficiary received the whole $50,000 face value of Tory's policy.

- Consideration may be unequal
- The outcome depends on chance or uncertain event
- A legal bet is considered an aleatory contract

Unilateral Contract: One sided agreement, where only the insurer is legally bound. In an insurance contract, only the insurance company is legally bound to do anything (pay claims). Uni=one lateral=side, one side - the insurance company is legally bound. The insured does not make a promise to pay premiums, however, if premiums are not paid the insurer has the right to cancel the contract.

Personal Contract: Most insurance contracts are personal contracts between the insurance company and the insured individual, and are not transferable to another person without the insurer's consent. Life insurance is an exception to this standard as the owner of the policy has no bearing on the insurer's assumed risk. Therefore, people who own life insurance are called policyowners rather than policyholders and may transfer or assign ownership by notifying the company.

Conditional Contract: Insurance contracts are conditional because certain conditions must be met by all parties in the contract. Hence, benefits depend on the occurrence of an event covered by contract. This is needed when a loss occurs for the contract to be legally enforceable.

Valued vs. Indemnity: Life insurance contracts are **valued** contracts, which means it will pay a stated amount. **Health insurance** contracts are **indemnity** contracts and will only reimburse the actual cost of the loss (pay medical bills, etc.). The **Principle of Indemnity** is to restore the insured to the same financial condition as that which existed prior to the loss. You cannot profit from an indemnity contract.

Utmost Good Faith: Implies that there will be no attempt by either party to misrepresent, conceal or commit fraud as it pertains to insurance policies. Insurance applicants are required to make full, fair, and honest disclosure of the risk to the agent and insurer. Agents and insurers are required to accurately explain the policy's features, benefits, advantages, and possible disadvantages to an applicant.

Warranties: Statements made by the applicant guaranteed to be true (name, DOB) becomes part of the contract and if found to be untrue, can be ground for revoking the contract.

Representations: Statements made by the applicant believed to be true (height, weight) are not part of the contract and need to be true only to the extent that they are material and related to the risk.

Concealment: Withholding of information or facts by the applicant (smoker, diabetes).

Insurable Interest: Requires that an individual have a valid concern for the continuation of the life or well-being of the person insured. Without insurable interest, an insurance contract is not legally enforceable and would be considered a wagering contract. Insurable interest only needs to exist at the time of the application (the inception of the contract)**.** *For example, spouses would typically have insurable interest on each other's life childhood friends typically would not have insurable interest on each other's life. An employer may have insurable interest on a key employee's life.*

Reasonable Expectations: A concept which states that the insured is entitled to coverage under a policy that a sensible and prudent person would expect it to provide**.** Reinforces the rule that ambiguities in insurance contracts should be interpreted in favor of the policyholder.

Stranger-Originated Life Insurance: In Stranger-Originated Life Insurance, or **STOLI**, a consumer purchases a life insurance policy with the agreement that a third-party agent/broker or investor will purchase the consumer's policy and receive the proceeds as a profit upon the consumer's death. This differs from a standard insurance policy because a 3rd party OWNER will be the one benefiting from the death of the insured. **STOLI** policies are typically illegal as they violate insurable interest requirements.

- **AGENT AUTHORITY**

A relationship in which one person is authorized to represent and act for another person or company is established through the law of agency**.** In applying the law of agency, the insurance company (insurer) is the principal. An agent or producer will always be deemed to represent the insurance company and not the applicant. Regarding the insurance contract, any knowledge of the agent is considered to be the knowledge of the insurance company (insurer). If the agent is working within the conditions of his/her contract, the insurance company is fully responsible.

Authorized agent: a person who acts for another person or entity and has the power to bind the principal to contracts.

Agents are granted **authority** by the insurer through the agency contract to transact insurance or adjust claims on their behalf. Some common tasks agents are authorized to perform include solicit applications, collect premiums, render services to prospects, and describes the company's insurance policies.

Types of agent authority:

- **Express:** Express authority is the explicit authority granted to the agent by the insurer as written in the agency contract. *For example, solicit applications and collect premiums.*
- **Implied:** The unwritten authority of a producer to perform incidental acts necessary to fulfill the purpose of the agency agreement (otherwise unwritten in the contract). *For example, since you are authorized to solicit applications and collect premiums, it is implied that you are authorized to set appointments.*
- **Apparent**: Apparent authority deals with the relationship between the insurer, the agent, and the customer. It is the appearance of authority based on the agent-insurer relationship. Apparent authority is a situation in which the insurer gives the customer reasonable belief that an agent has the power and authority to bind the principal. *For example, since you have all of the insurance application forms and business cards it is apparent to the customer that you are able to help them apply for insurance.*

➢ OTHER LEGAL CONCEPTS

Fiduciary Responsibility – Because the agent handles money of the insured and insurer, he/she has a fiduciary responsibility. A fiduciary is someone in a position of trust and confidence. *With insurance, for example, it is illegal for agents to mix premiums collected from applicants with their own personal funds.* This is called **commingling**.

Fraud: Fraud is an intentional misrepresentation or concealment of material fact made by one party in order to cheat another party out of something that has economic value. An insurer may void an insurance policy if a misrepresentation on the application is proven to be material.

Waiver: Waiver is the voluntarily giving up of a known right. *For example, if an insurer chose to approve an application and issue a policy without requesting a medical exam they cannot later request a medical exam to for that policy in the future.*

Estoppel: The legal process of preventing one party from reclaiming a right that was waived.

Parol Evidence Rule: Rule that prevents parties in a contract from changing the meaning of a written contract by introducing oral or written evidence made prior to the formation of the contract, but are not part of the contract.

Subrogation is the right for an insurer to pursue a third party that caused an insurance loss to the insured. This is done as a means of recovering the amount of the claim paid to the insured for the loss. *For example, if an insured driver's car is totaled through the fault of another driver; the insurance carrier will reimburse the covered driver as described in the policy and take legal action against the driver-at-fault in an attempt to recuperate the cost of that claim.*

Void and Voidable Contracts: A void contract is an agreement that does not have legal effect, and therefore is not a contract. Void contracts are not enforceable by either party. Unlike a void contract, a voidable contract is a valid, binding contract which can be voided at the request of a party with the right to reject.

Cancellation: the voluntary act of terminating an insurance contract.

Endorsement: a written form attached to an insurance policy that alters the policy's coverage, terms, or conditions.

Brokers: a broker or independent agent may represent a number of insurance companies under separate contractual agreements.

Professional Liability Insurance (Errors and omissions): A professional liability for which producers can be sued for mistakes of putting a policy into effect. under the insurance, the insurer agrees to pay sums that the agent legally is obligated to pay for injuries resulting from professional services that he rendered or failed to render.

Life Insurance Policies

- **TYPES OF LIFE INSURANCE POLICIES**

1. **Industrial life:** insurance issues very small face amounts, such as $1,000 or $2,000. Premiums are paid weekly and collected by debit agents. They were designed for burial coverage.

2. **Group life:** insurance written for members of a group, such as a place of employment, association, or a union. Coverage is provided to the members of that group under one **master contract.** The group is underwritten as a whole, not on each individual member. One of the benefits of group life coverage is usually there is no evidence of insurability required.

3. **Ordinary life:** Is made up of several types of individual life insurance, such as temporary **(term)**, permanent **(whole)**.

Term life insurance gives you the greatest amount of coverage for a limited period of time. Term insurance is only good for a limited period of time because it has a TERMination date. Term insurance is an inexpensive type of insurance, making it an attractive option for large policies. Term life is the CHEAPEST type of pure life insurance, and due to having a termination date and not having any cash value, it will ALWAYS be cheaper than a whole life policy with the same face value. It provides a pure death protection since it only pays a death benefit if the insured dies during the policy term.

Term is often renewal and convertible. For example, if you have a 10-year renewable and convertible term; After the 10 years are up, the policy terminates or you can renew it. If you renew it the premium price will go up, and you will have the policy for another 10 years. This cycle continues until you are too old to renew or it's too expensive. All TERM insurance has a final TERMINATION date where you can no longer renew it. If the policy is CONVERTIBLE, you can CONVERT it to whole life (think rent to own) at any time. Any time you renew or convert ANY type of insurance, you do not have to worry about your health, is your insurability is locked in. However, the price will always go up, because your attained (or current) age is used for your new policy. Term is typically thought of as "renting" -- you have a roof over your head, but they're going to raise the price and until it no longer makes sense for you to keep it or at some point they TERMINATE the contract and kick you out.

Level term: also called level premium level term, has a level face amount and level premiums. Premiums tend to be higher than annual renewable term because they are level throughout the policy period. However, the premiums will increase at each renewal. Life insurance written to cover a need for a specified period of time at the lowest premium is called Level Term Insurance. Term insurance always expires at the end of the policy period. For example, if D needs life insurance that provides coverage for the remainder of her working years and wants to pay as little as possible, D would need Level term. Level term provides a fixed, low premium in exchange for coverage which lasts a specified time period.

Decreasing term: Term life insurance that provides an **annually decreasing face amount over time** with **level premiums**. These policies are usually used for **mortgage protection.** A decreasing term policy is a type of life policy which has a death benefit that adjusts periodically (according to a schedule) and is written for a specific period of time. Decreasing term policies are usually written for a mortgage or other debt that typically decreases over time until it is paid off. For example, a 15 year decreasing term policy could protect a 15-year mortgage. As the mortgage balance reduces each year, the face value of the insurance policy will adjust accordingly to match. After the mortgage is paid off, the insurance policy will expire.

Credit policies are typically purchased using a decreasing term life insurance policy, with the term matched to the length of the loan period and the decreasing insurance amount matched to the declining

loan balance. Since Credit life insurance is designed to cover the life of a debtor and pay the amount due on a loan if the debtor dies before the loan is repaid, credit policies can only be purchased for up to the amount of the debt or loan outstanding. For example, if you wanted an insurance policy to protect a $20,000, 5-year auto loan, you would use a 5 year decreasing term life insurance policy with an initial face value of $20,000. You will pay the same level premium every month for the 5-year term of the policy. The face value will start out at $20,000 and change according to a schedule (the decreasing balance of the auto loan). After 5 years, the car will be paid for and the insurance policy will no longer be needed.

Increasing term: Term life insurance that provides an **increasing face amount** over time based on specific amounts or a percentage of the original face amount.

Convertible term: A term life policy has a provision that allows policyowners to **convert their term insurance into permanent policies without showing proof of insurability.** Convertible Term provides temporary coverage that may be changed to permanent coverage without evidence of insurability. For example, if you take out a term insurance policy when you are young to take advantage of your good health and the policy's lower premium, but want the option convert the policy to a permanent one for final expense benefits once your finances improve, you would want a convertible term life policy. The conversion privilege of a group term life policy allows an individual to leave the group term (temporary) plan and convert his or her insurance to an individual (permanent) policy without providing evidence of insurability. The most important factor to consider when determining whether to convert term insurance at the insured's attained age or the insured's original age is the premium cost. The number one factor which impacts life insurance premium cost is the insureds current or attained age. For example, a $25,000 policy on a healthy 7-year-old boy will cost substantially less than a $25,000 policy on a 57-year-old man. Whether converting an individual or group term insurance policy, although your insurability is guaranteed, your age is typically reevaluated to your current (attained) age, not left at the age you were when you applied for the original term policy. Convertible Term would allow you to take your temporary coverage and change it to permanent coverage without evidence of insurability or good health, but your premiums will increase due to using your attained age.

Renewable term: Term insurance that guarantees the insured the right to continue term coverage after expiration of the initial policy period **without having to prove insurability**. Renewable Term provides temporary level coverage at the lowest possible cost for a limited period of time, but then allows the policyowner to renew the policy to maintain coverage past the policy's termination. When a term policy is renewed, the insured does not have to prove insurability. However, the premium price will rise because the insurance company will use the insureds current or attained age to determine the new premiums. If a customer wanted coverage at the lowest possible cost that was good for a limited period of time, but offered the ability to continue the coverage after the expiration, the customer would want a renewable term policy.

Annual renewable term: Term coverage that provides a level face amount that renews annually. This type of coverage is guaranteed renewable annually without proof of insurability.

Term – Rider

A term rider is a type of life insurance product which covers children under their parent's policy. Family plan policies usually cover the family head with permanent insurance, and the coverage on the spouse and children is term insurance in the form of a rider. A term rider is always level term. This is cheaper than every family member getting their own policy. For example, the main policy may be on Dad, then mom and the children are riding on (attached to) to dad's policy as term riders. Term riders allow for additional family members to be covered under one policy by attaching everyone to a main policy. Term riders can also allow an applicant to have excess coverage by adding an additional term rider for them to the main policy.

Whole life: insurance that provides death benefits for the entire life of the insured. It also provides living benefits in the form of cash values. It matures at age 100 and normally has a level premium.

Whole Life Insurance: Provides both living **and** death benefits. Provides permanent life insurance protection for the insured's **entire life.** It also provides living benefits such as **cash value and policy loans.**

Advantages of whole life insurance:

- Covers the entire life of the insured
- Living benefits - cash value and policy loans
- Fixed premiums

Drawbacks of whole life insurance:

- Protection is more expensive because of living benefits
- Premium paying period may extend beyond the income-earning years

Whole life is often compared to BUYING like BUYING a house: You can pay the house off slowly or quickly, but once it's paid for, you still own the house. There are several types of whole life All whole life has the same type of benefits. The only difference in "types" of whole life is how the policy is paid. Some will be paid straight until death or age 100, some will be paid for after a few years or by a specific age, some may give you a little discount in the early years to help you get started, etc. All whole life lasts until death or age 100, has a fixed premium, and level benefit with cash value accumulation, regardless of how it is paid. **Types of whole life insurance include:**

1. straight whole life
2. limited pay whole life
3. single-premium whole life
4. modified whole life
5. graded whole life

Straight life: This is basic whole life insurance with a level face amount and fixed premiums payable over the insured's entire life. **Premium payments made until death of insured or age 100 (maturity of policy).**

Limited Pay life: This is whole life insurance where the insured is covered for his entire life, but **premiums are paid for a limited time. As the premium payment period shortens, cash values increase faster and the fixed premiums are higher.** For example, under a life paid-up at 65 policy, premiums are only paid until the insured is 65 years old. With a 20-pay life policy, the insured only pays for 20 years. These policies are in effect until the insured's death or they reach age 100.

Single premium whole life: Allows the insured to pay the entire premium in one lump-sum and have coverage for the insured's entire life.

- An immediate nonforfeiture value is created
- An immediate cash value is created
- A large part of the premium is used to set up the policy's reserve

Modified whole life: Low premiums in the early years and jumps to a higher premium in the later years and remains fixed thereafter. Premiums increase just once.

Graded whole life: Under a typical graded premium life insurance policy, the premium increases yearly for a stated number of years, then remains level. Premiums continue to stay level for the remainder of the policy. For example, a policy can start out low in a graded whole life and increase a small amount every year up until the fifth year, then levels off for the remainder of the policy.

SPECIAL USE POLICIES

In addition to the basic types of life insurance policies, there are a number of "special use" policies insurance companies offer. Many of these are a combination or "packaging" of different policy types, designed to serve a variety of needs.

Family Plan Policies: These are designed to insure all family members under one policy. **Usually the family head is covered by permanent (whole life) insurance and the spouse/children are included on the same policy as level term life riders (family term riders) .** The term coverage on the spouse and children are normally convertible to permanent coverage without evidence of insurability. *If "Attached" to someone else's policy. Think side car on motorcycle. Riders must RIDE on something.*

Family Plan Policy Example:
Husband – Whole Life Policy
Wife (spouse) – Term Policy – convertible without proof of insurability
Children – Term Policies – convertible usually at age 18 or 21 without proof of insurability;
premium remains same regardless of the number of children

Family Income Policies: Whole life and decreasing term insurance (begins date of purchase). Provides monthly income to a beneficiary if death occurs during a specified period after date of purchase. If the insured dies after the specified period, only the face value is paid to the beneficiary since the decreasing term insurance expired. *Income this concern typically DECREASES over time because the household shrinks. They use decreasing term instead of level. With decreasing term, the benefit begins to decrease as soon as the policy begins*.

Family Maintenance Policy: Whole life and level term (begins date of death). Provides income to a beneficiary for a selected period of time if an insured die during that period. At the end of the income-paying period, the beneficiary also receives the entire face amount of the policy. If an insured die after the end of the selected period, the beneficiary receives only the face value of the policy. *Maintenance "maintains" the family using level term. This means the family will receive a benefit for so many years after the insured's death.*

Multiple protection policies: Pays a benefit of double or triple the face amount if death occurs during a specified period. If death occurs after the period has expired, only the policy face amount is paid. The period may be for a specified number of years - 10, 15, or 20 years or to a specified age such as 65. These policies are combinations of permanent insurance and level term insurance.

Joint Life Policy: A policy that covers two or more people. The age of the insureds are **"averaged"** and a single premium is charged. It uses permanent insurance (as opposed to term) and pays a death benefit when **one** of the insureds dies. The survivors then have the option of purchasing an individual policy without evidence of insurability. The premium for a joint life policy is less than the premium for separate, multiple policies. *ONE policy*
covers two. Think "joint accounts" with a bank. One account, two people.

Note: A variation of the joint life policy is the **joint and survivor policy, or a "survivorship life policy"** (it can also be known as a "second to die" policy). This plan also covers **two lives**, but the benefit is paid upon the death of the **last surviving insured**.

Compared to the combined premium for separate life insurance policies on two individuals, the premium for a survivorship life policy is **lower**.

Juvenile Insurance: Life insurance which is written on the lives of a minor is called juvenile insurance. The adult applicant is usually the premium payor as well, until the child comes of age and is able to take over the payments. **A payor provision is typically attached to juvenile policies. It provides that, in the event of death or disability of the adult premium payor, the premiums will be waived until the child reaches a specified age (such as 18, 21, or 25).** *Payor Provision protects the insured in the event the **PAYOR** dies or is disabled.*

Credit life insurance: is designed to cover the life of a debtor and pay the amount due on a loan if the debtor dies before the loan is repaid. **It is normally issued in an amount not to exceed the outstanding loan balance and is usually paid entirely by the borrower. A decreasing term policy is most often used.**

NONTRADITIONAL LIFE POLICIES

In the 1980s, insurance companies introduced a number of **new life products designed to keep up with inflation and are interest-sensitive,** most of which are more flexible in design and provisions than their traditional counterparts. **The most notable of these are interest-sensitive whole life, adjustable life, universal life, variable life, and variable universal life.**

Interest-Sensitive Whole Life: Interest-sensitive life insurance is a type of whole life insurance where the cash value can increase beyond the stated guarantee if economic conditions warrant. This is also called current assumption whole life insurance. It also gives the insured the opportunity to either increase the face amount or use the extra cash value to lower future premiums. Premiums can vary to reflect the insurer's changing assumptions with regard to its death, investment, and expense factors. CAWL (current assumption whole life) policies are almost always a MEC due to accelerated premiums.

Adjustable life policies: are distinguished by their **flexibility** that comes from **combining term and whole life insurance into a single plan.**

- The policyowner determines how much face amount protection is needed and how much premium the policyowner wants to pay
- **Adjustable life insurance allows you to vary your coverage as your needs change without requiring evidence of insurability**
- Consequently, no new policy needs to be issued when changes are desired
- Adjustable life has all the usual features of level premium cash value life insurance

Universal life: is a variation of whole life insurance, **characterized by considerable flexibility**.

- Changes may be made with **relative ease by the policyowner** with these flexible-premium policies
- *Investment Gains go towards cash value*
- Unlike whole life (with its fixed premiums, fixed face amounts, and fixed cash value accumulations) **universal life allows its policyowners to determine the amount and frequency of premium payments which will adjust the policy face amount**
- Basic characteristics of a universal life policy are flexible premiums, flexible benefits, no minimum death benefit, and cash value withdrawals
- Cash value accumulations are subject to a **minimum interest guarantee**
- Any surrender charges of a universal policy must be disclosed

Equity Index Universal Life insurance (EIUL): A permanent life insurance policy that allows policyholders to tie accumulation values to a stock market index, **like the S&P 500.** Indexed universal life insurance policies typically contain **a minimum guaranteed fixed interest rate** component along with the indexed account option**. Indexed policies give policyholders the security of fixed universal life insurance with the growth potential of a variable policy linked to indexed returns.** Potential extra interest based on the investments of the company's general account.

Modified Endowment Contracts (MEC): **A policy that is overfunded, according to IRS tables, is classified as a Modified Endowment Contract.** Policies that do not meet the 7-pay test are considered MEC's and will lose favorable tax treatment. The 7-pay test is a limitation on the total amount you can pay into your policy in the first seven years of its existence. The test is designed to discourage premium schedules that would result in a paid-up policy before the end of a seven-year period. For example, if yearly premium is $500, in a seven year period a total amount paid would equal $3,500. If you paid $3,501, it has now exceeded the 7-pay test and is no longer a life insurance contract. It will now be taxed as an investment.

- If withdrawn prior to age 59 ½, there is a 10% penalty.
- Taxation only occurs when cash is distributed
- Funds withdrawn from a MEC are subject to last-in first-out (LIFO) tax treatment, which assumes that the investment or earnings portion of the contract's values is withdrawn first (making these funds fully taxable as ordinary income).
- Penalty taxes on premature distributions from a modified endowment contract (MEC) normally apply to policy loans

VARIABLE INSURANCE PRODUCTS

Note: Because of the transfer of investment risk from the insurer to the policyowner, variable insurance products are considered securities contracts as well as insurance contracts. A producer is required to register with the National Association of Securities Dealers to sell variable products.

Variable whole life insurance: was created to help offset the effects of inflation on death benefits. It's permanent life insurance with many of the same characteristics of traditional whole life insurance. The main difference is the manner in which the policy's values are invested. With traditional whole life, these values are kept in the insurer's general accounts and invested in conservative investments selected by the insurer to match its contractual guarantees and liabilities. With variable life insurance policies, the policy values are invested in the **insurer's separate accounts** which house common stock, bond, money market, and other securities investment options. Values held in these separate accounts are invested in riskier, but potentially higher yielding, assets than those held in the general account. **The basic characteristics of a variable life policy are: fixed premiums, a guaranteed minimum death benefit which fluctuates over the minimum, and cash values which fluctuate and are not guaranteed.**

Variable universal life (VUL): is a type of life insurance that builds cash value. It combines all the characteristics of a universal life and variable life. In a VUL, the cash value can be invested in a wide variety of separate accounts, similar to mutual funds, and the choice of which of the available separate accounts to use is entirely up to the contract owner. **The 'variable' component in the name refers to the ability to invest in separate accounts whose values vary**—they vary because they are invested in stock and/or bond markets. **The 'universal' component in the name refers to the flexibility the owner has in making premium payments.** This provides the policyowner with flexible premiums, adjustable death benefits, a guaranteed minimum death benefit and gives the insured growth potential for higher returns, but also potential for loss. Evidence of insurability can be required for an individual covered by a variable universal life policy when the death benefit is **increased.**

Life Insurance Provisions, Options, and Riders

➢ Required Provisions

Insuring Clause (or Insuring Agreement): The insurer's basic promise to pay specified benefits to a designated person in the event of a covered loss. The insuring clause is the part of the health insurance policy that states the kind of benefits provided and the circumstances under which they will be paid. The purpose of the insuring clause in an insurance policy is to specify the scope and limits of the coverage provided. The insuring clause is the part of the insurance policy that identifies the specific type of benefits or or services that are covered by that policy and the circumstances under which they will be paid. Any promises the INSURER makes will be in the INSURING clause.

Consideration Clause: A policyowner must pay a premium in exchange for the insurer's promise to pay benefits. **A policyowner's consideration consists of completing the application and paying the initial premium.** The amount and frequency of premium payments are contained in the consideration clause. In insurance, the insurance company exchanges the promises in the policy for a two-part consideration from the insured. (Consideration is an exchange of something of value on which a contract is based). An insurance contract is valid only if the insured provides consideration in the form of the initial full minimum premium required and the statements made in the application. The applicant begs, "Please CONSIDER me for insurance. Here is my completed application, my initial premium, and how much money/how often I agree to pay. Please CONSIDER me!"

Entire Contract

- The entire contract includes the actual policy and the application

- It states that nothing outside of the contract (the contract includes the signed application and any attached policy riders) can be considered part of the contract
- It also assures the policyowner that no changes will be made to the contract or waive any of the provisions after it has been issued, even if the insurer makes policy changes that affect all policy sales in the future. This, however, does not prevent a mutually agreeable change or modifying the contract after it has been issued.
- Any change to a policy must be made with the approval of an executive officer of the insurance company whose approval must be endorsed on the policy or attached in a rider
- This mandatory health policy provision states that the policy, including endorsements and attached papers, constitutes the entire insurance contract between the parties
- We can't send you additional paperwork later. THE ENTIRE POLICY AND APPLICATION is sent to you and that makes up your ENTIRE CONTRACT.

Grace Period: The period of time policyowners are allowed to pay an overdue premium during which the policy remains in force, usually 30 days. If an insured dies during the Grace Period of a life insurance policy before paying the required annual premium, the beneficiary will receive **the face amount of the policy less any required premiums.** The purpose of the Grace Period is to give the policyowner additional time to pay overdue premiums. The policyowner is given a number of days after the premium due date during which time the premium payment may be delayed without penalty and the policy continues in force. *Grace period is the same definition for your insurance bill as it is for all of your other bills. Don't pick it as an answer if the question isn't talking about paying your bill late and keeping your insurance.*

Reinstatement: Permits the policyowner to reinstate a policy that has lapsed- as long as the policyowner can provide proof of insurability and pays all back premiums, outstanding loans, and interest. Most states allow reinstatement up to 3 years after a policy has lapsed. However, some states are 5-7 years. The Reinstatement provision specifies that if an insured fails to pay a renewal premium within the time granted but the insurer subsequently accepts the premium, coverage may be restored. Under certain conditions, a policy that has lapsed may be reinstated. Reinstatement is automatic if the delinquent premium is accepted by the company or its authorized agent and the company does not require an application for reinstatement. If it takes no action on the application for 45 days, the policy is reinstated automatically. To reinstate any policy, you need: A reinstatement application, statement of good health, all back premiums.

Incontestable Clause: The clause in a life insurance contract that prohibits the insurer from questioning the validity of the contract after a certain period of time has elapsed.

Misstatement of Age or Sex: Allows the insurer to adjust the policy benefits if the insured's age or sex is misstated on the policy application. The misstatement of age provision allows the insurer to adjust the benefit payable if the age of the insured was misstated when application for the policy was made. The insurer can adjust the benefit to what the premiums paid would have purchased at the insured's actual age. If the insured was older at the time of application than is shown in the policy, benefits would be reduced accordingly. The reverse would be true if the insured were younger than listed in the application

Policy Loan Provisions: Policies that have cash value also have policy loan and withdrawal provisions. These policies must begin to build cash value after a certain number of years. In most states, this is 3 years. These loans, with interest, cannot exceed the guaranteed cash value or the policy is no longer in force. The policyowner has the right to the policy's cash value. Policy loans are not taxable. Any loans with interest due at the time of death will be deducted from the insured's policy proceeds.

Automatic Premium Loans: Allows the insurer to automatically use the policy cash value to pay an overdue premium. There is no cost for this provision. *Automatic Premium Loans: Like using a savings account for overdraft protection, but*

there's no fee, just interest for borrowing your money. If you don't pay it back, interest is added to the loan, it also will be subtracted from any death benefit or cash surrenders if not paid back first.

Owner's Rights Provision

Defines the person who may name and change beneficiaries, select options available under the policy, and receive any financial benefits from the policy.

Assignment Clause or Provisions: The right to transfer policy rights to another person or entity. The new owner is known as the assignee.

Absolute assignment: When the assignee receives full control of the policy and rights to the policy benefits from the current policyowner. Under an absolute assignment, the transfer is complete and irrevocable, and the assignee receives full control over the policy and full rights to its benefits.

Collateral assignment: The partial and temporary transfer of rights to another person or entity. Collateral assignments are usually intended for securing a loan with a creditor. A collateral assignment is one in which the policy is assigned to a creditor as security, or collateral, for a debt. If the insured dies (or sometimes becomes totally\permanently disabled), the creditor is entitled to be reimbursed out of the benefit proceeds for the amount owed. The insured's beneficiary is then entitled to any excess of policy proceeds over the amount due to the creditor.

Free Look: The policyowner is permitted a certain number of days once the policy is delivered to look over the policy and return it for a refund of all premiums paid.

Notice of Claim

- The notice of claim provision describes the policyowner's obligation to notify the insurance company of a claim in a reasonable period of time
- Typically, the period is 20 days after the occurrence or a commencement of the loss, or as soon thereafter as is reasonably possible
- You need to let the insurance company know that you are going to be filing a claim, so they are expecting your claim forms.

Claim Forms

- It is the company's responsibility to supply a claim form to an insured within 15 days after receiving notice of claim
- If the insurance company fails to send out the claim forms within the time period required by the provision, the insured should submit the claim in any form, which must be accepted by the company as adequate proof of loss
- You can submit your claim using a napkin and crayon as long as you provide all the necessary information.

Proof of Loss

- The statement that an insured must give an insurance company to show that a loss actually occurred is a Proof of Loss

- After a loss occurs, or after the company becomes liable for periodic payments (e.g., disability income benefits), the claimant has 90 days in which to submit proof of loss.
- Insurance company can't pay you if you don't prove there is a loss.

Time of Payment of Claims

- The time of payment of claims provision provides for immediate payment of the claim after the insurer receives notification and proof of loss.
- If the claim involves disability income payments, they must be paid at least monthly if not at more frequent intervals specified in the policy
- The purpose of the Time of Payment of Claims provision is to prevent the insurance company from delaying claim payments
- You did your part (Paid your bill and got injured/sick/ etc.) now the insurance company has to immediately do our part (Pay you) and it can't be less often than monthly, or you wouldn't be able to pay your bills.

Payment of Claims

- The payment of claims provision in an insurance contract specifies how and to whom claim payments are to be made.
- Payments for loss of life are to be made to the designated beneficiary
- If no beneficiary has been named, death proceeds are to be paid to the deceased insured's estate. Claims other than death benefits are to be paid to the insured.
- Should the insurance company pay you, or the doctor, or someone else?

Physical Exam and Autopsy

- The physical exam and autopsy provision entitles a company, at its own expense, to make physical examinations of the insured at reasonable intervals during the period of a claim, unless it's forbidden by state law.
- Forget everything you learned on "Law and Order," only the state can forbid an autopsy. You gave up your (and your families) rights to refuse when you applied for insurance.

Legal Actions

- The insured cannot take legal action against the company in a claim dispute until after 60 days from the time the insured submits proof of loss.
- The Legal Action provision provides the insurer adequate time to research a claim
- At least give the insurance company 2 months to take care of you before you take them to court.

Beneficiary designation

- Where the policyowner indicates who is to receive the proceeds.

Change of Beneficiary

- The insured, as policyowner, may change the beneficiary designation at any time unless a beneficiary has been named irrevocably.

Settlement options

- Where the ways in which the proceeds can be paid out or settled are explained.

Discretionary Provision

- Limits the way a court can review a claim denial and makes it difficult for the court to conduct a fair review of the claim. Some states have enacted laws that prohibit Discretionary provision because they are designed to protect the insurance company.

Change of Occupation

- This provision also allows the insurer to reduce the maximum benefit payable under the policy if the insured switches to a more hazardous occupation or to reduce the premium rate charged if the insured changes to a less hazardous occupation

Unpaid Premiums

- If there is an unpaid premium at the time a claim becomes payable, the amount of the premium is to be deducted from the sum payable to the insured or beneficiary.

Cancellation

- Though prohibited in a number of states, the provision for cancellation gives the company the right to cancel the policy at any time with 45 days' written notice to the insured
- This notice must also be given when the insurer refuses to renew a policy or change the premium rates
- If the cancellation is for nonpayment of premium, the insurer must give 10 days' written notice to the insured, unless the premiums are due monthly or more frequently
- The cancellation provision also allows the insured to cancel the policy any time after the policy's original term has expired by notifying the insurer in writing

Conformity with State Statutes

- Any policy provision that is in conflict with state statutes in the state where the insured lives at the time the policy is issued is automatically amended to conform with the minimum statutory requirements.

Illegal Occupation

- The illegal occupation provision specifies that the insurer is not liable for losses attributed to the insured’s being connected with a felony or participation in any illegal occupation.

Intoxicants and Narcotics

- The insurer is not liable for any loss attributed to the insured while intoxicated or under the influence of narcotics.
- Losses due to injuries sustained while committing a felony, or attempting to do so, also may be excluded

The Policy Face

- The Policy face contains a summary of the type of policy and the coverage provided by the policy. It Identifies the insured, the term of the policy (the effective date and termination date), and how the policy can be renewed.

Guaranteed Insurability Option Rider

- Allows a policyowner to purchase additional life insurance coverage at specified dates without providing evidence of insurability.

Payor Provision (Rider)

- Provides waiver of premiums if the adult premium-payor should die or, with some policies, become totally disabled.

Accidental Death Benefit Rider (Double Indemnity)

- Provides an additional amount of insurance usually equal to the face amount of the base policy if the cause of death was an accident.

COMMON EXCLUSIONS OR RESTRICTIONS

- Exclusions: A feature of a life insurance policy stating that the policy will not cover certain risks.
- Exclusions and restrictions are situations or conditions which are not covered or covered with substantial limits.
- The common ones are injuries due to war or an act of war, self-inflicted injuries, and those incurred while the insured is serving as a pilot or crew member of an aircraft
- Other exclusions are losses resulting from suicide, hernia (as an accidental injury), riots, or the use of drugs or narcotics
- Losses due to injuries sustained while committing a felony, or attempting to do so, also may be excluded
- Foreign travel may not be excluded in every instance, but extended stays overseas or foreign residence may cause a loss of benefits
- Occupational injuries and illnesses are covered by Workers' Compensation and typically excluded
- The exclusions section is NOT included in the policy face (first page of an insurance policy)
- Suicide Clause: The policy will be voided and no death benefit will be paid if the insured commits suicide within 1 year from policy issuance. The primary purpose of a suicide provision is to protect the insurer against the purchase of a policy in contemplation of suicide.
- Aviation: The insurer will not pay the claim if the insured dies due to involvement with aviation, such as a military pilot flying a jet aircraft.
- War or Military Service: The insurer will not pay the claim if the insured dies while in active military service or due to an act of war.

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

Waivers for Impairments

- When an insurance company does not cover a loss due to a specific condition the insured has. This is usually called an impairment rider.
- If the insured's condition improves, the company may be willing to remove the waiver.

Policy Options

Nonforfeiture Options *You are closing your account (surrendering your policy), what do you want us to do with your cash (so you don't forfeit it)?*

When a policyowner decides he does not want his life insurance policy anymore, he has the option to surrender his policy. If there is cash value remaining he must use one of the following nonforfeiture options:

Cash Surrender: allows the policyowner to receive the policy's cash value. Policyowner no longer has coverage at this point. Normally, the maximum length of time a life insurance company may legally defer paying the cash value of a surrendered policy is 6 months (Delayed Payment provision).

Extended Term Option: permits the policyowner to use the policy's cash value to buy level, extended term insurance for a specified period. No premium payments are made. The coverage provided with the extended term nonforfeiture option is equal to the net death benefit of the lapsed policy.

Reduced Paid-Up Option: the policyowner pays no more premiums but the face amount is decreased.

Dividend Options

Participating policies pay dividends to policyowners if the company's operations result in a divisible surplus. Recall that dividends are a return of overcharged premiums, and are therefore not taxable. Insurers typically pay dividends on an annual basis. The following dividend options are available to policyowners for settling dividend payments.

- Cash Option: Take the cash – It's your money, you can take it and run.
- Reduced Premiums Option: Reduces premium payments – "Just keep them and next year don't charge me so much.
- Accumulate Interest Option: Allows dividends to accumulate interest. *Interest is the only thing you can be charged tax on.*
- Paid-Up Additions Option: Purchase single payment whole life coverage
- One-Year Term Option: Purchase one-year term protection

Keep in mind, with dividends, the policy is still active.

POLICY RIDERS

Waiver of Premium Rider: Allows the policyowner to waive premium payments during a disability and keeps the policy in force. It does not provide cash payments to the policyowner. The disability must be total and permanent and have sustained through the waiting period (90 days or 6 months). After a certain age (usually 60 or 65), the waiver of premium rider is void. *Waiver: Covers the PRIMARY INSURED. Does NOT provide income. Is NOT a loan. The insurance company is "waiving" the premiums" it's just as if the insured made the premiums every month.*

Payor Rider (or Payor Clause): If the individual paying the premiums on a juvenile life policy becomes disabled or dies, the Payor Rider ensures that premiums will be waived.

Accelerated Benefit Rider: Allows the insured to receive a portion of the death benefit prior to death if the insured has a terminal illness and expected to die within 1-2 years. Whatever amount is withdrawn in an accelerated death benefit will decrease the death benefit when death occurs. *Accelerated Benefit: Your doctor said you are going to die, so you aren't going to stop paying your insurance (since you know you'll need it soon). Insurance company now knows you are going to die soon which means they are going to have to pay out the benefit. To make things a little easier and less stressful, they will give YOU some of the proceeds NOW and deduct from what would go to your beneficiary at your death.*

Accidental Death Benefit Rider (multiple indemnity): Pays an additional sum to the beneficiary if the insured dies due to an accident. The amount paid is a multiple of the policy face amount such as double or triple the original benefit. Truly the cheapest way to add a lot of coverage for a period of time.

Accidental Death and Dismemberment: May be added to a life insurance policy. Pays benefits for dismemberment and accidental death. Pays a principal sum for loss of both hands, both arms, both legs, or loss of vision in both eyes. *AD&D: FACE VALUE= amount for accidental loss or loss of 2 hands, feet, eye sight, etc. ½ face value for loss of 1 foot, hand eye, etc. One foot and one hand = 100% face value.*

Guaranteed Insurability Rider (future increase option): Permits the policyowner to buy additional permanent life insurance coverage at specific points of time in the future without submitting proof of insurability. It also includes specific events like marriage and births, without requiring the proof of insurability. Usually the benefit is allowed every 3 years, up to the original face amount of the policy.

Cost of Living Rider: Allows the policy face amount to be adjusted to account for inflation based on the consumer price index.

Return of Premium Rider: pays the total amount of premiums paid into the policy in addition to the face value, as long as the insured dies within a certain time period specified in the policy. It also returns premiums to the living insured at the end of a specified period of time, as long as the premiums have been paid.

Automatic Premium Loan Rider: Allows the insurance company to deduct overdue premium from an insured's cash value by the end of the grace period if a payment is missed on a life policy. The insurance company can AUTOMATICALLY take out a LOAN for you against your CASH VALUE to cover your PREMIUM in the event they don't receive payment from you. This can continue for as long as they don't receive a payment and you still have cash value. Once all of your cash value is gone, if you don't start paying, your policy will lapse. This is just like any other cash value loan.

Life Insurance Premiums, Proceeds and Beneficiaries

➢ PRIMARY FACTORS IN PREMIUM CALCULATIONS

Once an insurance company determines that an applicant is insurable, they need to establish the payment (premium) for the insurance policy.

Life insurance premiums are calculated based on the following three primary factors:

1. Mortality Factor
2. Interest Factor
3. Expense Factor

Mortality Factor: A measure of the number of deaths in a given population. Insurance companies use mortality tables to help predict the life expectancy and probability of death for a given group.

Interest Factor: Insurance companies invest the premiums they receive in an effort to earn interest. **The rate of earnings on investments** is one of the ways an insurance company can reduce premium rates. A large portion of every premium received is invested to earn interest. The interest earnings reduce the premium amount that otherwise would be required from policyowners.

Expense Factor: Insurance companies are just like any other business. They have operating expenses which need to be factored into the premiums. The expense factor is also known as the **loading charge.** *Each insurance policy an insurer issues must carry its proportionate share of the costs for employees' salaries, agents' commissions, utilities, rent or mortgage payments, maintenance costs, supplies, and other administrative expenses.*

Benefits : The number and kinds of benefits provided by a policy affect the premium rate The greater the benefits, the higher the premium. To state it another way, the greater the risk to the company, the higher the premium.

Other factors that impact the premium amount include:

- **Age:** The older the person, the higher probability of death and disability
- **Sex / Gender:** Women tend to live longer than men, so their premiums are usually lower
- **Health:** Poor health increases probability of death and disability
- **Occupation**: Hazardous job increases the risk of loss
- **Hobbies**: High risk hobbies also increase the risk of loss
- **Habits**: Tobacco use presents a higher risk than non-smokers

Remember these are typically only important at time of application. If you tell them you never went sky diving (and that is true) then 5 years later you go sky diving for the first time and die, they will pay.

Mode refers to the premium payment schedule and **permits the policyowner to select the timing of premium payments.** Insurance policy rates are based on the assumption that the premium will be paid annually at the beginning of the policy year and that the company will have the premium to invest (interest factor) for a full year. If the policyowner chooses to pay the premium more than once per year (example monthly, quarterly, semi-annually) there normally will be an additional charge because the company will have additional charges in billing and collecting the premium payments.

The more payments you make, the more it is going to cost you overall. Ideally, if you could make 1 payment in a lump sum to start and "Pay up" the policy, you would save the most amount of money. Also, your cash value would begin accumulating right away. The higher your premium payments are, the quicker you accumulate cash value.

Premium Payment Options:

- Annual
- Semi-Annual
- Quarterly
- Monthly

Note: The higher the frequency of payments = higher premiums

Level Premium Funding: The policyowner pays more in the early years for protection to help cover the cost in later years, which allows the premiums to remain level throughout the life of the policy. **The shorter the premium-paying period, the higher the premiums, and vice versa.**

Single Premium Funding: The policyowner pays a single premium that provides protection for life as a paid-up policy. Normally associated with whole life insurance

Reserves vs. Cash Value

Reserves: Money that together with future premiums, interest, and survivorship benefits will fulfill an insurance company's obligations to pay future claims.

Cash Value: Cash value applies to the savings element of whole life insurance policies that are payable before death. However, during the early years of a whole life insurance policy, the savings portion brings very little return compared to the premiums paid.

Comparing life insurance policy costs

Life insurance cost comparison methods are used to evaluate the cost of one life insurance policy in relation to another so that consumers can be better informed when shopping for the most competitively priced offering for their particular needs. Although the cost of life insurance depends largely upon an individual's specific circumstances and requirements, cost estimates are nonetheless useful so that the consumer has the opportunity to consider every factor when making a buying decision. When evaluating different policies, it's not enough to simply compare premiums. A lower premium does not automatically mean a lower-cost policy. To that extent, cost indexes have been developed to help in the process of measuring an insurance policy's actual cost. Here are two of these indexes:

Surrender Cost Index: Uses a complicated calculation formula where the net cost is averaged over the number of years the policy was in force to arrive at the average cost-per-thousand for a policy that is surrendered for its cash value at the end of that period.

Net Payment Cost Index: Uses the same the same formula as the Surrender Cost Index with the exception that it doesn't assume that the policy will be surrendered at the end of the period. The net payment cost index is useful if one's primary concern is the amount of death benefits provided in the policy. It is helpful in comparing future costs, such as in 10 to 20 years, if one will continue to pay premiums and does not take the policy's cash value.

Tax Treatment of Premiums

Premiums paid on individual life insurance policies are generally not deductible. Premiums for life insurance used for business purposes are generally not tax-deductible. Here are the exceptions to these rules:

• Premiums used for a charity are tax-deductible.

• Life insurance premiums paid by an ex-spouse as court-ordered alimony are tax- deductible.

• Employer-paid premiums used to fund group life insurance for the benefit of employees are tax-deductible.

Tax Treatment of Cash Values
If cash value is surrendered, the portion that exceeds the premiums paid is taxable. For policies that are not surrendered, the cash value grows tax-free. As long as the cash value stays in the policy taxes will never be imposed on any portion, not even the amount that exceeds the cost basis.

Policy Proceeds
Death Benefits: Death benefits are paid out in a variety of ways. These methods are known as settlement options. The policyowner may select a settlement option at the time of the application and may change the option at anytime during the life of the insured. Once selected, the settlement option cannot be changed by the beneficiary.

Death Benefit Settlement Options

- **Lump Sum:** Death benefit is paid in a single payment, minus any outstanding policy loan balances and overdue premiums. The lump sum option is considered the automatic (or "default") option for most life insurance contracts.
- **Interest Only:** Insurance company holds death benefit for a period of time and pays only the interest earned to beneficiaries. A minimum rate of interest is guaranteed and the interest must be paid at least annually.
- **Fixed Period:** Also called period certain. The fixed period option is when the insurer pays proceeds (including interest and principal) in minimum guaranteed dollar payments over a specified number of years. Part of the installments paid to a beneficiary consists of interest calculated on the proceeds of the policy. The dollar amount of each installment depends upon the total number of installments.
- **Fixed Amount:** The fixed amount installment option pays a fixed death benefit in specified installment amounts until the proceeds are exhausted. The larger the installment payment the shorter the payout period.
- **Life Income:** The life income option provides the beneficiary with an income that they cannot outlive. Installment payments are guaranteed for as long as the recipient lives, the amount of each installment is based on the recipient's life expectancy and the amount of principal. This gives the potential for a greater return, or the potential for greater loss, based on how long the insured lives
- **Joint and Survivor:** Benefits will be paid on a life-long basis to **two or more people**. This option may include a period certain and the amount payable is based on the ages of the beneficiaries.

Living Benefits: A living benefit is the option to use some of the future death benefit proceeds when they may be most needed, before their death, when the insured has a terminal illness.

Living Benefit Options

Accelerated Benefit – Allows someone that a physician certifies as terminally ill to access the death benefit. The amount of benefit received will be tax free.

Viatical Settlement – Allows someone with a terminal illness to sell their existing life insurance policy to a third party for a **percentage of the death benefit**. The new owner continues to make the premium payments and will eventually collect the entire death benefit.

Note: the original policyowner is called the Viator and the new third-party owner is called the Viatical, or sometimes referred to as the Viatee.

Tax Treatment of Proceeds

- Premiums: Not tax deductible
- Death Benefit: Tax- free if taken as a lump sum to a named beneficiary. Proceeds pass directly to the beneficiary and are **not subject to attachment by the insured's creditors**.
- Death Benefit Installments: Principal is tax- free – interest is taxable

Taxation of Proceeds Paid at Death

Life insurance proceeds paid to a beneficiary are usually tax free if taken as a lump sum. The exception to this rule is the **transfer for value rule**, which applies when a life insurance policy is sold to another party before the insured's death. Another tax cost typically associated with death is the **Federal estate tax** (although most relatively simple estates do not require the filing of an estate tax return).

Taxation of Proceeds Paid During the Insured's Lifetime

Policy Surrender: When a policy is surrendered for the cash value, some of the cash value received may be taxable, if the value was more than the amount of the premiums paid for the policy.

Accelerated Death Benefit: When benefits are paid under a life insurance policy to a terminally ill person, the benefits are received tax-free. To be considered terminally ill, a physician must certify that the person has a condition or illness that will result in death in two years.

Note: Most states still require a Viatical company to inform the client that under a Viatical arrangement the proceeds could be taxable in certain situations and recommend they consult a tax advisor

1035 Exchange: When an existing life insurance policy is assigned to another insurer for a new contract, the transaction may be treated for tax purposes as a Section 1035 exchange. Policy exchanges that qualify as a 1035 exchange are not taxable.

BENEFICIARIES

Qualifications

There are very few restrictions on who may be named a beneficiary of a life insurance policy. The **policyowner** is the ultimate decision maker. However, in the underwriting process, the underwriter may consider the issue of insurable interest. When the policyowner lists themselves as the beneficiary, they
will require proof of insurable interest. *Remember, insurable interest ONLY applies at time of APPLICATION.*

Who can be beneficiaries?

- Individuals
- Businesses
- Trust
- Estates
- Charities
- Minors

- **Class (having a group named as the beneficiary instead, such as the children of the insured)**

Types of Beneficiaries

A beneficiary can be either specific (a person identified by name and relationship), or a class designation (a group of individuals such as the "children of the insured"). If no one named, or if all beneficiaries die before the insured dies, death benefit will go to insured's estate.

By Order of Succession:

- **Primary:** First in line to receive death benefit proceeds
- **Secondary (contingent):** Second in line to receive death benefit proceeds if primary beneficiary dies first
- **Tertiary:** Third in line to receive death benefit proceeds. If no one named, death benefit will go to insured's estate.

Distribution by Descent

- **Per Stirpes**: (meaning by the bloodline) In the event that a beneficiary dies before the insured, benefits from that policy will be paid to that beneficiary's heirs.
- **Per Capita**: (meaning by the head) Evenly distributes benefits among all named living beneficiaries.

Changing a Beneficiary

A policyowner may change the beneficiary at any time. There may be limitations, however.

- **Revocable Beneficiary – The policyowner may change the beneficiary at any time without notifying or getting permission from the beneficiary.**
- **Irrevocable Beneficiary – An irrevocable designation may not be changed without the written consent of the beneficiary.** The irrevocable beneficiary has a vested interest in the policy, therefore **the policyowner may not exercise certain rights (such as taking out a policy loan) without the consent of the beneficiary.**

Special Situations

- **Simultaneous Death**: If the insured and the primary beneficiary die at approximately the same time for a common accident with no clear evidence as to who died first, the **Uniform Simultaneous Death Act** law will assume that the primary died first, this allows the death benefit proceeds to be paid to the **contingent beneficiaries**.
- **Common Disaster Provision:** With a common disaster provision, a policyowner can be sure that if both the insured and the primary beneficiary die within a short period of time, **the death benefits will be paid to the contingent beneficiary.**
- **Spendthrift Clause:** Prevents a beneficiary from recklessly spending benefits by requiring the benefits to be paid in fixed amounts or installments over a certain period of time.
- **Facility of Payment:** allows the insurance company to pay all or part of proceeds to someone not named in the policy that has a valid right. This is usually done on behalf of a minor or when the named beneficiary is deceased.

Life Insurance Underwriting and Policy Issue

➢ PURPOSE OF UNDERWRITING

Underwriting: is another term for risk selection. It is the process used by an insurance company to determine whether or not an applicant is insurable and if so, how much to charge for premiums. The underwriter will utilize several different types of information in determining the insurability of the individual. **This is called risk classification.** Material facts can affect an applicant being accepted or rejected.

One of the main responsibilities of an underwriter is to protect the insurer against adverse selection.

➢ UNDERWRITING PROCESS

The underwriting process involves reviewing and evaluating information about the applicant and establishing individual against the insurer's standards and guidelines for insurability and premium rates. The larger the policy, the more comprehensive and diligent the underwriting process.

The most common sources of underwriting information include:

1. The application
2. The medical report
3. Attending physician's statement
4. The Medical Information Bureau
5. Special Questionnaires
6. Inspection Reports
7. Credit Reports

Application: The application is the starting point and basic source of information used by the insurance company in the risk selection. Although applications differ from company to company they all have the following same components. **Insurable interest must exist between the policyowner and insured at the time when the application is made.**

Insurable interest exists when the death of the insured would have a clear financial impact on the policyowner.

Application

Part I of the Application

- General Information – Age, DOB, Sex, Address, Marital Status, Occupation,
- Details about the requested insurance coverage:
  - Type of policy
  - Amount of insurance
  - Name and relationship of the beneficiary
  - Other insurance the proposed insured owns
- Other information personal information
  - Tobacco use
  - Hazardous hobby
  - Foreign travel
  - Aviation activity
  - Military service.

Part II of the Application

- Medical Information – Health History
  - Part II focuses on the proposed insured's health and asks a number of questions about the health history.
  - This medical section must be completed in its entirety for every application.
  - Depending on the proposed policy, this section may or may not be all that is required in the way of medical information.
- The individual to be insured may be required to take a medical exam and/or provide a blood test or urine specimen.

Part III of the Application

- Agent's Report (Statement) - Agent's personal observations of the applicant.
- Includes the applicant's financial condition, character, background, purpose of sale, and how long agent has known the applicant.
- Part III of the application is often called the agent's report. This is where the agent reports personal observations about the proposed insured.
- Because the agent represents the interests of the insurance company, the agent is expected to complete this part of the application fully and truthfully.

Policies below a certain face amount, such as $50,000 or even $100,000, will not require additional medical information, other than provided by the application. However, they require a medical report for further information.

Credit Reports: An applicant's credit history is sometimes used for underwriting and to determine the likelihood of making premium payments. The Fair Credit Reporting Act requires the applicant be notified in writing if a credit report will be used. The applicant must also be notified if the premium is increased because of a credit rating.

Warranty: Warranties are statements that are **guaranteed to be literally true.** A warranty that is not literally true in every detail, even if made in error, is sufficient to render a policy void.

Representation: Statements made by applicants that are substantially true to the best of their knowledge, but not warrantied as exact in every detail.

Medical Report: A medical report is sometimes used for underwriting policies with higher face amounts. If the information in the medical section warrants further investigation into the applicant's medical conditions, the underwriter may need an attending physician statement (APS).

Inspection Reports: This report provides information about the applicant's character, lifestyle, and financial stability. Inspection reports are usually only requested for larger coverages because they add expense to the underwriting process. When an investigative consumer report is used in connection with an insurance application, the applicant has the right to receive a copy of the report. However, company rules vary as to the sizes of policies that require a report by an outside agency. Companies are allowed to obtain inspection reports under The Fair Credit Reporting Act. The Fair Credit Reporting Act of 1970 (FCRA) regulates the way credit information is collected and used to protect the rights of consumers for whom an inspection or credit report has been requested. It established procedures for the collection and disclosure of information obtained on consumers through investigation and credit reports. If an insurance company requests a credit report, the consumer must be notified in writing. This report provides information about the applicant's character, lifestyle, and financial stability. When an investigative consumer report is used in connection with an insurance application, the applicant has the right to receive a copy of the report.

Medical Information Bureau (MIB): The MIB is a nonprofit trade organization which maintains medical information about individuals. Information from the MIB is used by life and health insurers. This helps insurance companies from adverse selection by applicants, as it detects misrepresentations, helps identify fraudulent information, and controls the cost of insurance. Information released from the Medical Information Bureau about a proposed insured may be released to the proposed insured's physician. Information received from the Medical Information Bureau (MIB) about a proposed insured may be released to the proposed insured's physician. An insurance company would NOT notify the MIB if an application is declined.

USA Patriot Act: The USA Patriot Act was enacted in 2001. It requires insurance companies to establish formal anti-money laundering programs. The purpose of the act is to detect and deter terrorism. A life insurance policy can be cash-surrendered, which can be an attractive money laundering vehicle because it allows criminals or terrorists to put dirty money in and take clean money out in the form of an insurance company check.

Special Questionnaires: are used for applicants involved in special circumstances, such as aviation, military service, or hazardous occupations or hobbies. The questionnaire provides details on how much of the applicant's time is spent in these activities.

Fair Credit Reporting Act of 1970 (FCRA): Regulates the way credit information is collected and used to protect the rights of consumers for whom an inspection or credit report has been requested. Information regarding an individual's credit standing and general reputation is contained in a **consumer report**. **It established procedures for the collection and disclosure of information obtained on consumers through investigation and credit reports.** If an insurance company requests a credit report, the consumer must be notified in writing.

- The **producer** must provide a privacy notice to an applicant if personal information about that applicant is disclosed and is passed along to the insurer or its affiliates.
- **The applicant has the right to receive a copy of the report** when an investigative consumer report is used in connection with an insurance application.

Applicant Ratings: once all the information about a given applicant has been reviewed, the underwriter seeks to classify the risk that the applicant poses to the insurer. This is evaluation is known as **risk classification**.

- **CLASSIFICATIONS OF RISK**

Once all the information about a given applicant has been reviewed, the **underwriter** will utilize several different types of information in determining the insurability of the individual and the risk that the applicant poses to the insurer. This is evaluation is known as **risk classification**. The producer must provide a **privacy notice** to an applicant if personal information about that applicant is disclosed and is passed along to the insurer or its affiliates. The following rating classification system is used to categorize the favorability of a given risk:

Preferred – Low Risk – Lower Premiums. Lower risks tend to have lower premiums. Some of the following may result in a policy being issued with a preferred insurance premium:

- Applicant is nonsmoker and/or nondrinker
- Good personal/family health history

Standard - Average Risk – No Extra Ratings or Restrictions standard terms and rates

Substandard – High Risk – Rated Up – Higher Premiums chronic conditions, insulin diabetes, heart disease

Declined – Not Insurable – Potential of Loss to Insurance Company is Too High *terminal illness, too many chronic conditions*

➢ FIELD UNDERWRITING PROCEDURES

Field underwriting is completed by the agent. Unlike the insurer, the agent has face-to-face contact with the applicant, which can aid the insurer in risk selection. As field underwriters, agents help reduce the chance of adverse selection, assure that the application is filled out completely and correctly, collect the initial premium, and deliver the policy. Other duties include:

- Forwarding the application to the insurer in a timely manner
- Seeking additional information about the applicant's medical history if requested
- Notifying the insurer of any suspected misstatements in the application
- Assuring the application is filled out completely and correctly
- Collect the initial premium
- In addition to that, agents have the responsibility and duty to solicit good business. Therefore, an agent's solicitation and prospecting efforts should focus on cases that fall within the insurer's underwriting guidelines and represent profitable business to the insurer.

Upon policy delivery, agents must deliver the life insurance buyer's guide and policy summary to the applicant. A life insurance producer may also be required to obtain a signature on a statement of good health at the time of policy delivery.

Application Errors

- If an agent realizes that an applicant has made an error on an application, the agent must correct the information and have the applicant initial the changes
- An incomplete application will be returned to the agent
- The agent can NEVER change the application without the customer present to initial the changes

Buyer's Guide: provides general information about the types of life insurance policies available, in language that can be understood by the average person. *This is whole life, this is term life this is what variable life means, etc.*

Policy Summary: provides specific information about the policy purchased, such as the premium and benefits. *Mom calls you excited because she bought new health insurance. This allows you to quickly see what "health insurance" specifically did she buy: Medicare Supplement, Major Medical, Critical Illness, Long-term Care?*

Suitability Form Ensures that the customer is best suited for the policy they are purchasing. Prevents the sale of unnecessary insurance for example a 75 year old customer living off of Social Security would not be suited for a single premium deferred annuity because they would be giving up a large some of cash that they could live on and possibly not live long enough to collect on the annuity.

Signatures: The agent and the applicant are required to sign the application. If the applicant is someone other than the proposed insured, except for a minor child, the proposed insured must also sign the application. Having an applicant that is different from the insured (parent and minor child) is considered third party ownership In most states, once a minor reaches the age of 15, he is eligible to contract for an insurance policy.

If an agent fails to deliver a fully completed and accurate application, the insurance company will return the application to the agent.

When an applicant makes a mistake in the information given to an agent in completing the application, the applicant can have the agent correct the information, but the applicant must initial the correction. If, however, the company discovers the

mistake before the applicant, then it usually returns the application to the agent. The agent then corrects the mistake with the applicant and has the applicant initial the change.

An incomplete application will be returned to the producer and a new one will have to be filled out.

Premiums and Receipts

Agents should make every effort to collect the initial premium with the application. However, if premium is not collected with the application, the policy will not become valid until the initial premium is collected.

The agent issues the applicant a **premium receipt** upon collecting the initial premium.

The only time a customer will receive a receipt is if they pay their initial premium at the time of application. No receipt will be given at any other time.

There are two types of premium receipts that determine when coverage will begin. These are conditional receipts and binding receipts.

- **Conditional Receipt:** The producer issues a conditional receipt to the applicant when the application and premium are collected. **The conditional receipt denotes that coverage will be effective once certain conditions are met.** If the insurer accepts the coverage as applied for, the coverage will take effect from the date of the application or medical exam, whichever is later.

- **Binding Receipt:** The binding receipt or the temporary insurance agreement provides coverage from the date of the application regardless of whether the applicant is insurable. Coverage usually lasts for 30 to 60 days, or until the insurer accepts or declines the coverage. Binding receipts are rarely used in life insurance, and are primarily used in auto and homeowners' insurance. Under a binding receipt, coverage is guaranteed until the insurer formally rejects the application. This may also be described as Insurer is bound to coverage until the application is formally rejected. Even if the proposed insured is ultimately found to be uninsurable, coverage is still guaranteed until rejection of the application

Effective Date of Coverage

As explained under conditional receipt, coverage is not effective without collection of the initial premium, approval of the application, and policy issuance and delivery. If the initial premium does not accompany the application, the premium must be collected by the agent. In some cases, the insurer requires the agent to collect a statement of good health from the insured at the time of delivery. If the initial premium is not submitted with the application, the policy effective date is established by insurer. In this case, it could be the date of policy issuance, or the date the policy is delivered to the applicant, premium collected, and statement of continued good health signed.

The effective date is important for two reasons: it identifies when the coverage is effective and establishes the date by which future annual premiums must be paid.

Backdating: is the process of predating the application a certain number of months to achieve a lower premium. A lower age results in a lower premium. A backdated application results in a backdated policy effective date, if approved by the insurer. Applications usually can only be backdated up to 6 months. This process is also known as "saves age". In addition, policyowners are required to pay all back-due premiums and the next premium is due at the backdated anniversary date.

Insurance contract is sent to the sales agent for delivery to the applicant. The policy usually is not sent to the policyowner because it should be explained by the sales agent to the policyowner.

Policy Issue

- Happens when the insurer "approves" the application, they are "issuing the policy"
- Technically a policy could be **ISSUED** and not delivered for days or weeks later

➢ **POLICY ISSUE AND DELIVERY**

Constructive Delivery: policy delivery may be accomplished without physically delivering the policy into the policyowner's possession. Constructive policy occurs if the insurance company intentionally relinquishes all control over the policy and turns it over to someone acting for the policyowner, including the company's own agent. Mailing the policy to the agent for unconditional delivery to the policyowner also constitutes constructive delivery, even if the agent never personally delivers the policy. **If the company instructs the agent not to deliver the policy unless the applicant is in good health, there is no constructive delivery.**

The Statement of good health: verifies that the insured has not become ill, injured or disabled during the policy approval process (time between submitting application and delivery of the policy), or did not submit the initial premium with the application. Is used when the applicant did not submit the initial premium with the application In such cases, common company practice requires that, before leaving the policy, the agent must collect the premium and obtain from the insured a signed statement attesting to the insured's continued good health. Also used when reinstating a policy

Personal delivery: of the policy is a good practice as it allows the producer to explain the coverage to the insured (such as the riders, provisions, and options). Personal delivery also builds trust and reinforces the need for the coverage. All of the following acts can be considered means of delivery: mailing policy to the agent; mailing the policy to applicant; and the agent personally delivering policy.

Group Life Insurance

➢ PRINCIPLES OF GROUP INSURANCE

Different from individual life insurance, which is written on a single life, group life insurance is written on more than one life. Group life insurance is usually written for employee-employer groups and is most often written as an annual renewable term policy. **An important underwriting principle of group life insurance is that all or a large percentage of persons in the group must be covered by the insurance.**

Contributory and Noncontributory Plans

Contributory – **An employee group plan in which employees share the cost.** Insurance company requires that at least 75% of all employees participate.

Noncontributory – **An employee group plan in which employees do NOT share in the cost.** Insurance company requires that 100% of all employees be eligible.

➢ FEATURES OF GROUP INSURANCE

The following are the two features that separate group insurance from individual insurance.

- the individual does not have to provide evidence of insurability- group underwriting is involved
- are not issued as individual policies- master contracts are issued instead
- low cost due to lower administrative, operational, and selling expenses associated with group plans
- flow of insureds: entering and exiting under the policy as they join and leave the group

- typically issued as level term insurance, which provides a fixed amount of coverage throughout the term of the contract

Note: Since the individual does not own or control the policy, they are issued a **certificate of insurance to prove they have coverage.** The actual policy, which is called the master policy, is issued to the employer.

- Employees are called – **certificate holders**
- Employers are called- contract holders

➢ ELIGIBLE GROUPS

Group life insurance can be formed by the following as well as other organizations, just as long as they are formed for a reason other than to purchase insurance. **There is no minimum # of members required for group life insurance.**

- **Single –employee groups**
- **Multiple-employee groups**
- **Labor Unions**
- **Trade Associations**
- **Credit/Debit groups**
- **Fraternal Organizations**
- Trustee Groups (Established by two or more employers or labor unions)

Eligibility of Group Members – (employees)

- **Employee must be full time and actively working**

- **If contributory, employees must approve of automatic payroll deduction**
- **New employee probationary period is usually 1 to 6 months**
- **The employee has 31 days during the enrollment period to sign up, otherwise they may need to provide evidence of insurability**

➢ Classification of Risk

Insurers require that a minimum number of group members/employees participate in a group insurance plan in
order to minimize adverse selection. Adverse selection means that the people most likely to need life insurance will purchase life insurance in greater numbers than those in good health.

After all necessary information is collected on an applicant, the underwriter will classify the applicant based on the degree of risk assumed.

The following rating classification system is used to categorize the favorability of a given risk:

►Preferred – Low Risk – Lower Premiums
►Standard - Average Risk – No Extra Ratings or Restrictions
►Substandard – High Risk – Rated Up – Higher Premiums

►Declined – Not Insurable – Potential of Loss to Insurance Company is Too High

Lower risks tend to have lower premiums. If an applicant is too risky, the insurer will decline coverage.

➢ Types of Group Life Insurance Plans

Group Term Life: Life insurance is normally offered as a guaranteed annual renewable term policy. The policy is issued for one year and may be renewed annually without evidence of insurability at the discretion of the policyowner.

Group Whole Life: Though not as common, group whole life offers permanent protection for insured members under the group.

Note: The most common types of Group Permanent (whole life) plans are: **Group Ordinary, Group Paid-Up, and Group Universal Life**

Dependent Coverage: Most group life insurance policies cover the member's dependents, as long as the amount of coverage does not exceed 50% of the insured member's coverage.

➢ Taxation of Group Life Insurance Plans

For a group life insurance plan to receive favorable tax treatment, there are certain requirements in place. This makes sure that the average employee is not discriminated against in favor of higher level employees.

Determining eligibility: Must benefit at least 70% of all employees. At least 85% of all participating employees must not be key employees.

Premiums for group life insurance: If paid by the employee are not tax-deductible. However, if the employer pays, it can deduct the premiums it pays as a business expense. Proceeds from a group life policy are tax-free if taken in a lump-sum. Proceeds taken in installments will be subject to taxes on the interest portion of the installments.

How Benefits are Determined

Most employers will establish benefit schedules according to the following:

- **Earnings**
- **Employment position**
- **Flat benefit**

Conversion to Individual Policy: If a member's coverage is terminated, the member and his dependents may convert their group coverage to individual whole life coverage, **without having to show proof of insurability.**

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

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

➢ OTHER FORMS OF GROUP LIFE INSURANCE

The following are other types of life insurance issued as group plans:

Franchise Life Insurance: This is used where participants are employees of a common employer (i.e., the employer may operate several companies) or are members of a common association or society. The employer/association/society is a sponsor of the plan and may or may not contribute to the premium payments. Unlike the employer's group plan, each individual will be issued an individual policy which will remain in force as long as premiums are paid and the employee/member maintains their relationship with the sponsor. These are used by small groups who individually do not meet the state's minimum numbers required by law.

Group Credit Life: These are set-up by banks, finance companies, etc. in case the insured dies before a loan is repaid. Policy benefits are paid to the creditor and used to settle the loan balance. The premiums are usually paid by the borrower. A **decreasing term policy** is commonly used.

Blanket Life Insurance: Covers groups of people exposed to the same hazard, such as passengers on an airplane. No one is named on the policy and there is not a certificate of coverage given out. Individuals are only covered for the common hazard.

Group Permanent Life: Some group life plans are permanent (whole life) plans, using some form of permanent or whole life insurance as the underlying policy. The most common types of permanent group plans are group ordinary, group paid-up, and group universal life.

Annuities

PURPOSE AND FUNCTION

While life insurance protects against the risk of premature death, **annuities protect against the risk of living too long.**

Annuity Basics

Annuities: are ways of providing a stream of income for a guaranteed period of time.

- Simply stated, an annuity is started with a large sum of money that will be paid out in installments over a period of time or until the money is all gone.
- The monthly amount of benefit an annuitant receives is based on factors such as: principle amount, rate of interest the annuity earns, and length of payout period.

Contract owner: The individual who purchases the annuity pays the premiums and has rights of ownership.

- An owner may be the annuitant, the beneficiary, or neither

Annuitant: The income benefits distributed at regular intervals during the liquidation phase of an annuity contract are normally payable to the **annuitant.**

Beneficiary: The beneficiary is the person who receives survivor benefits upon the annuitant's death.

Accumulation Period vs. Annuity Period

Most annuities have two phases, the accumulation period and the annuity period.

- **Accumulation Period:** The pay-in period, where the contract owner makes the purchase payments. The accumulation period of an annuity normally may continue after the purchase payments cease.
- **Annuity Period:** This is also called the liquidation period, annuitization period, or pay- out period. This is the time when the money that has accrued during the accumulation period is paid-out in the form of payments to the annuitant.

STRUCTURE AND DESIGN

Funding Method *When defining an annuity, (describe how you pay for it) + (describe how they pay you) SINGLE PREMIUM (You pay once) + DEFERRED (They start paying you at least a year later). You CANNOT make installment payments and get paid immediately.*

- Single Payment – Lump Sum
- Periodic Payments - Installments paid over a period of time

Date Income Payments Begin

Immediate Annuities: **Purchased with a single lump sum payment, and will start providing income payments within the first year, but usually starting 30 days from the purchase date.** It's purpose is to provide for liquidation of a principle sum.

- Commonly used to structure the payment of liability insurance settlements, lottery winnings, and other large sums

- This type of annuity is usually called a **Single Premium Immediate Annuity** (SPIA)

Deferred Annuities: will start providing income payments after the first year. Deferred annuities are usually purchased with either a single lump sum payment known as **a Single Premium Deferred Annuity** (SPDA) or from monthly payments known as **Flexible Premium Deferred Annuity** (FPDA). A Fixed Deferred Annuity, for example, pays out a fixed amount for life starting at a future date. **Interest credited to the cash values of annuities are deferred until distribution.** Other characteristics of deferred annuities include:

- When a deferred annuity is cancelled during the early contract years, the insurer normally will assess a back-end load known as a **surrender charge**
- The **"bailout"** feature, sometimes found in single premium deferred annuity contracts, waives surrender charges when the interest rate falls below a stated level
- Before a deferred annuity contract can be terminated for its surrender value, the insurer must first obtain authorization from the **owner**
- **The accumulation value of a deferred annuity is equal to the sum of premium paid plus interest earned minus expenses and withdrawals**

PAY OUT OPTIONS

Straight Life Income Payout Option: pays the annuitant a guaranteed income for the annuitant's lifetime. When the annuitant dies, no further payments are made to anyone. This offers protection against **exhaustion of savings due to longevity**.

Cash Refund Payout Option: Pays a guaranteed income to the annuitant for life. If the annuitant dies before all the money is gone, a lump-sum cash payment of the remaining funds are paid out to the annuitant's beneficiary.

Installment Refund Payout Option: Pays a guaranteed income to the annuitant for life. If the annuitant dies before the money is gone, the beneficiary will continue to receive the same monthly installment payments.

Life with Period Certain Payout Option (life income with term certain): is designed to pay the annuitant guaranteed payments for the life of the annuitant or for a specific period of time for the beneficiary. It provides that benefit payments will continue for a minimum number of years regardless of when the annuitant dies.

- For example, if an annuitant has a 20 year period certain and dies after 10 years, the beneficiary will receive payments for another 10 years.

Joint and Full Survivor Payout Option: Pays out the annuity to two or more people **until the last annuitant dies.** If one of them dies, the other will continue to receive the same income payments. There are two additional options made available with a joint and survivor payout:

- **Joint and two-thirds survivor:** Survivor will have payments reduced to two-thirds of the original payment.
- **Joint and one-half survivor:** Survivor will have payments reduced to one-half of the original payment.

Period Certain Payout Option: Pays guaranteed income payments for a certain period of time, such as 10 or 20 years, whether or not the annuitant is living.

INVESTMENT CONFIGURATION

Annuities can also be defined by their investment configuration, which will determine the amount of income the benefits pay. The two types of annuity classifications are fixed annuities and variable annuities.

Fixed Annuity: Provide a guaranteed rate of return. Fixed annuities credit interest at a rate no lower than the **contract guaranteed rate.**

Variable Annuity: Does not provide a guaranteed rate of return, because of the investment risk. **The cash value is based on the results of these investment funds.** A statement must be provided to the owner of the annuity at a minimum of once per year. Variable annuities can be classified as either immediate or deferred. Insurers that deal with variable annuities are subject to dual regulation by the SEC and the state's Office of Insurance Regulation.

- **Accumulation Units:** In a variable annuity, the value of the accumulation units varies depending on the value of the stock investment that is a part of a variable annuity.
- **Annuity Units:** At the time the variable annuity is to be paid out to the annuitant, the accumulations are converted into annuity units. These payouts can vary from month to month depending on the investment results. The number of units doesn't change, but the value does. The amount of each variable annuity benefit paid to an annuitant varies according to the market value of the securities backing it.

Equity Indexed Annuities: A type of fixed annuity that offers the potential for a higher return than a standard fixed annuity. They are sometimes tied to the Standard and Poor's 500 or the Composite Stock Price Index.
Single-life annuities: Characterized by having only one annuitant.
Tax-sheltered annuities: Limited exclusively for employees of religious, charity, or educational groups.
- Also called 403(b) plans
- Accumulation payments often come from voluntary salary reductions
- The annuitant may have an individual account contract

Income Tax Treatment of Annuity Benefits: Annuity benefit payments consist of principal and interest. The portion of annuity benefits that consists of principal (premiums paid into the annuity during the accumulation period) are not taxed and is sometimes called the owner's **"cost basis"**. The portion of the annuity benefits that is interest earned on the principal is taxable as ordinary income. Interest income must be reported for federal income tax purposes **upon receiving distributions or income benefits from the contract.**

- **The exclusion ratio** is a simple way to determine what portion of each annuity benefit payment is taxable:

Exclusion ratio = Investment in the contract / Expected return

Partial Withdrawal: is taken from an annuity before age 59 ½ the withdrawal is considered 100% interest, and is therefore taxable as ordinary income.

A 10% tax penalty is applied if a distribution is received before the annuitant reaches age 59 ½.
After this age, withdrawals do not incur the 10% penalty tax, but are taxable as ordinary income.
1035 Exchange: applies to annuities. If an annuity is exchanged for another annuity, a gain (for tax purposes) is not realized. This is also true for a life insurance policy or an endowment contract exchanged for an annuity. However, an annuity cannot be exchanged for a life insurance policy.

SUITABILITY OF ANNUITY SALES FOR SENIOR CUSTOMERS
Senior Residents Age 65 or Older

When making recommendations to a senior consumer regarding the purchase or exchange of an annuity, an agent must have reasonable grounds for believing that this **recommendation is suitable for the senior consumer.** This recommendation should be based on the facts disclosed by the senior consumer. It should include an evaluation of his investments and other insurance products along with his financial situation and needs.

Social Security

- **PURPOSE**

The Social Security system provides a basic floor of protection to all working Americans against the financial problems brought on by death, disability, and aging. Social Security augments but does not replace a sound personal insurance plan. Unfortunately, too many Americans have come to expect Social Security will fulfill all their financial

needs. The consequence of this misunderstanding has been disillusionment by many who found, often too late, they were inadequately covered when they needed life insurance, disability income, or retirement income.

Social Security, also known as Old Age, Survivors, and Disability Insurance (OASDI), was signed into law in 1935 by President Roosevelt as part of the Social Security Act. Social Security was established during the Great Depression to assist the masses of people who could not afford to sustain their way of life because of unemployment, disability, illness, old age, or death.

- **WHO IS COVERED**

Social Security extends coverage to virtually every American who is employed or self-employed, with few exceptions. Those not covered include:

- Most federal employees hired before 1984 who are covered by Civil Service Retirement or another similar plan
- Approximately 25% of state and local government employees who are covered by a state pension program and elect not to participate in the Social Security Program
- Railroad workers covered under a separate federal program called the Railroad Retirement System

- **HOW BENEFITS ARE DETERMINED**

A person must be insured under the Social Security program for survivors, disability, or retirement benefits to pay. Social Security benefits are based on how long a covered worker has worked throughout his life.

Insured Status

Social Security establishes benefit eligibility based on an "insured" status. There are two types of insured statuses that qualify individuals for Social Security benefits:

- To obtain **Fully Insured Status**, a covered worker must accrue a total of 40 quarters of credit, which is about 10 years of work.
- To be considered **Currently Insured**, and thus eligible for limited survivor benefits, a worker must have earned 6 credits during the last 13-quarter period.

Social Security Payroll Taxes

- Funding for Social Security is collected from FICA payroll taxes.
- Social Security payroll taxes are collected from employers, employees, and self-employed individuals.
- FICA tax is applied to an employee's income up to a certain income amount. This amount is called the taxable wage base.
- There is a maximum amount of earnings that can be subject to Social Security tax each year. This amount is indexed each year to the national average wage index. This maximum applies to employers, employees, and self-employed individuals. Medicare Part A taxes are not subject to a maximum taxable wage cap.

Taxation of Social Security Benefits

- Social Security benefits are subject to federal income tax if the beneficiary files an individual tax return and his annual income is greater than $25,000.
- Joint filers will pay federal income tax on their Social Security benefits if their income is greater than $32,000.

Calculating Benefits

- Based on the individual's average monthly wage during his working years.
- The primary insurance amount (PIA) is used to establish the benefit. It is equal to the worker's full retirement benefit at age 65.
- If a worker retires early, for example at age 62, his retirement benefits will be 80% of his PIA and will remain lower for the covered worker's life.
- The PIA is based on the average earnings over your lifetime.

➢ **TYPES OF OASDI BENEFITS**

Survivors Benefits

Social Security Survivors benefits or death benefits: pay a lump-sum death benefit or monthly income to survivors of deceased covered workers.

Survivor's benefits: include a $255 lump-sum death benefit, surviving spouse benefits, child's benefit, and parent's benefit.

- A surviving spouse without dependent children is eligible for Social Security survivor benefits as early as age 60.
- Survivor benefits are also available to:
  - A spouse of any age who is caring for children under age 16
  - Children under age 18
  - Children under age 19 who are full time students
  - Children at any age if disabled before age 22 and remain disabled
- A Social Security benefit of 75% of the Primary Insurance Amount (PIA) is given to an underage child of a deceased worker.

Disability Benefits

- Only available to covered workers **who are fully insured,as defined by Social Security,** at the time of disability.
- Disability income benefits are paid to the covered worker in the amount of the PIA after a **5-month** waiting period.
- Only available prior to the age of 65
- Does not pay partial disability or short-term disability benefits
- Disability must be total and expected to last 12 months or end in death
- Benefits include monthly payments to the disabled worker, spousal benefits, and child's benefits.
- **Definition of Disability:** In order to be considered totally disabled, an individual has to qualify according the following requirements:
  - The inability to engage in any gainful work that exists in the national economy
  - The disability must result from a medically determinable physical or mental impairment that is expected to result in early death, or has lasted, or is expected to last for a continuous period of 12 months

Retirement Benefits

- Benefits are only available to covered workers who are fully insured upon retirement.
- Benefits are paid monthly.
- If a covered worker retires at the normal retirement age, he will receive 100% of the PIA.
- If a covered worker retires early at the age of 62, the maximum Social Security benefit is 80% of the PIA. This reduction remains all through retirement.

- Retirement benefits pay covered retired workers at least 62 years of age, their spouses and other eligible dependents monthly retirement income.
- Retirement benefits include monthly retirement payments to the covered worker, spousal benefits, and child's benefits.

Black-Out Period

- Benefits paid to the surviving spouse of a deceased person who was receiving Social Security.
- The "black-out period" begins when Social Security survivorship benefits cease.
- This is when the youngest child turns 16 years old, or immediately if there are no children.
- The "black-out period" ends when the surviving spouse turns at least 60 years old.

Retirement Plans

➢ QUALIFIED PLANS VERSUS NONQUALIFIED PLANS

Qualified plans are retirement plans that meet federal requirements and receive favorable tax treatment. Qualified plans provide tax benefits and must be approved by the IRS. The plans must be permanent, in writing, communicated to employees, defined contributions or benefits, and cannot favor highly paid employees, executives, or stockholders. The primary type of qualified plans includes defined benefit and defined contribution plans.

- To comply with ERISA minimum participation standards, qualified retirement plans must allow the enrollment of all employees over age 21 with one year experience.
- If more than 60% of a qualified retirement plan's assets are in key employee accounts, the plan is considered **"top heavy".**

Qualified plans have the following features:

- Employer's contributions are tax-deductible as a business expense.
- Employee contributions are made with pretax dollars – contributions are not taxed until withdrawn.
- Interest earned on contributions is tax-deferred until withdrawn upon retirement
- The annual addition to an employee's account in a qualified retirement plan cannot exceed the maximum limits set by the Internal Revenue Service

Nonqualified plans are characterized by the following:

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

Tax Benefits of Qualified Plans

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

Withdrawals and Taxation

Withdrawals by the employee are treated as **taxable income**. Withdrawals by the employee made prior to age 59 ½ are assessed an additional **10% penalty tax**. Distributions are mandatory by April 1st of the year following **age 70½,** and failure to take the required withdrawal results in a **50% excise tax** on those funds.

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

The Employee Retirement Income Security Act of 1974 (ERISA)

ERISA was enacted to provide minimum benefit standards for pension and employee benefits plans, including fiduciary responsibility, reporting and disclosure practices, and vesting rules. The overall purpose of ERISA is to protect the rights of workers covered under an employersponsored plan.

➢ EMPLOYER-SPONSORED PLANS

Defined Benefit Plans

Defined benefit plans pay a specified benefit amount upon the employee's retirement. When the term pension is used, it normally is referring to a defined benefit plan. The benefit is based on the employee's length of service and/or earnings. Defined benefit plans are mostly funded by individual and group deferred annuities.

Defined Contribution Plans

Defined contribution plans do not specify the exact benefit amount until distribution begins. Two main types of plans are profit-sharing and pension plans. The maximum contribution is the lesser of the employee's earnings or $49,000 per year. Here are some examples of defined contribution plans:

Profit-Sharing Plans

A type of retirement plan that sets aside a portion of the firm's net income for distributions to employees who qualify under the plan. Plans must provide participants with the formula the employer uses for contributions. The contributions may vary year to year, and contributions and interest are tax-deferred until withdrawal.

Pension Plans

Employers contribute to a plan based on the employee's compensation and years of service, not company profitability or performance.

Money Purchase Plans

Allow employers to contribute a fixed annual amount, apportioned to each participant, with benefits based on funds in the account upon retirement. *Target benefit plans* have a target benefit amount.

Stock Bonus Plans

These plans are similar to a profit-sharing plan, except that contributions by the employer do not depend on profits, and benefits are distributed in the form of company stock.

Other Employer-Sponsored Plans

Cash or Deferred Arrangement (401(k) Plans)

401(k) plans allow employers to make tax-deferred contributions to the participant, either by placing a cash bonus into the employee's account on a pre-tax basis or the individual taking a reduced salary with the reduction placed pre-tax in the account. The account's funds are taxable upon withdrawal.

Tax-Sheltered Annuity (403(b) Plans)

Tax-sheltered annuities are a special class of retirement plans available to employees of certain charitable, educational, or religious organizations.

➢ QUALIFIED PLANS FOR SMALL EMPLOYERS

Simplified Employee Plans (SEPs)

SEP's are basically an arrangement where an employee (including a self-employed individual) establishes and maintains an IRA to which the employer contributes. Employer contributions are not included in the employee's gross income. A primary difference between a SEP and an IRA is the much larger amount that can be contributed to an employee's SEP plan is the lesser of 25% of the employee's annual compensation.

Savings Incentive Match Plan for Employees (SIMPLE)

SIMPLE plans are available to small businesses (including tax exempt and government entities) that employ **no more than 100 employees who received at least $5,000 in compensation from the employer during the previous year**. An employer can choose to make nonelective contributions of

2% of compensation on behalf of each eligible employee. To establish a SIMPLE plan, the employer must not have a qualified plan in place.

Keogh Plans

Keogh or HR-10 plans are for self-employed persons, such as doctors, farmers, lawyers, or other sole-proprietors. Keoghs may be defined contribution or defined benefit plans. Defined contribution Keoghs have a maximum contribution of $49,000 per year, while defined benefit Keoghs have maximum benefits of $195,000 per year. Contributions are tax-deductible, and interest and dividends are tax-deferred.

➢ INDIVIDUAL RETIREMENT PLANS

IRAs are established by an individual who has earned income to save for retirement.

Traditional IRAs

Traditional IRAs allow for an individual to contribute a limited amount of money per year, and the interest earned is tax-deferred until withdrawal. Contribution limits are indexed annually, currently at $5,000 per year, with $6,000 for individuals age 50 or older. Some individuals may deduct contributions from their taxes based on their adjusted gross income (AGI), but all withdrawals are taxable income. If an individual or spouse does not have an employer retirement plan, the entire contribution is tax-deductible, regardless of AGI. **Withdrawals made prior to age 59 ½ are assessed an additional 10% penalty tax.**

To avoid penalties, traditional IRA owners must begin to receive payment from their accounts no later than April 1 in the year following the attainment of age 70 ½. Funds may be withdrawn prior to the employee reaching age 59 ½ without paying the 10% penalty tax (but the interest is still taxable) to the following: death, disability, first-time homebuyers up to $10,000, education (no dollar maximum), health insurance premiums if unemployed, qualified medical expenses.

Roth IRAs

Roth IRAs are designed so that withdrawals are received **income tax-free**. Contributions to Roth IRAs are subject to the same limits as traditional IRAs, but are not tax-deductible. Interest on contributions is not taxable as long as the withdrawal is a qualified distribution. *Qualified distributions* must occur after five years in the event of death or disability of the individual, up to $10,000 for first-time homebuyers, or at the age of 59 ½.

Rollovers

Rollovers are a transfer of funds from one IRA or qualified plan to another.

- Rollovers are subjected to **20% withholding tax** if eligible rollover funds are **received personally by a participant** in a qualified plan, unless the funds are deposited into a new IRA or qualified plan within 60 days of distribution.
- Funds that are transferred directly from one qualified IRA to another qualified IRA are not subject to this withholding tax. This also includes a trustee-to-trustee transfer of rollover funds instead of personally receiving the funds and then rolling them over. This election permits the participant to avoid mandatory income tax withholding on the amount transferred.
- A surviving spouse who inherits IRA benefits from a deceased spouse's qualified plan is eligible to establish a rollover IRA in their own name.
- Rollover contributions to an individual retirement annuity (IRA) are unlimited by dollar amount

➢ FEDERAL PENSION ACT OF 2006

This law sets forth standards for funding, participating, vesting, disclosure, and tax treatment of retirement plans.

- This Act improves the pension system and encourages employees to increase contributions to their employer-sponsored retirement plans. The provisions of the act have two main goals: addressing employers pension funds and assisting employees who are saving for retirement.

- It addresses employer responsibilities by requiring additional premiums for underfunded plans. It does this by requiring employers to obtain accurate assessments of the pension's financial obligations. It also closes loopholes by which underfunded plans skip payments and prevents employers with under- funded plans from promising extra benefits without first funding those benefits.

- It helps employees who save for retirement through qualified plans by: allowing employers to automatically enroll employees in defined compensation plans; provide more accurate information about accounts; increase access to professional advice about investments; allow for direct deposit of income tax refunds into IRA's; allow active military to make early penalty-free withdrawals; increase limits on contributions to all qualified plans; and provide for better portability for those plans.

➢ 1035 EXCHANGES

All of the following are types of insurance policy exchanges that can be made without current taxation:

- The exchange of a life insurance policy for an annuity
- An annuity exchanged for another annuity contract
- A life insurance policy exchanged for another life policy

The exchange of an annuity for a life insurance policy is NOT permitted

Uses of Life Insurance

The valuable role that life insurance plays in providing a death benefit is easily recognized. What is often overlooked or not understood are the many "living benefits" of life insurance-especially whole life insurance. Life insurance creates an immediate estate by paying a death benefit whenever the insured dies. The cash value feature of permanent insurance and the owner's right to borrow from the cash value make these policies an important source of funds to meet living needs.

This section reviews the more common uses of life insurance in meeting individual needs as well as business needs,
not only at the death of the policyowner, but also during the owner's life.

➢ DETERMINING THE PROPER INSURANCE AMOUNTS

1. **Human Life Value Approach:** Calculates the amount of money a person is expected to earn over his lifetime to determine the face amount of life insurance needed, thereby placing a dollar value on the life of an individual.

2. **Needs Approach:** A method of life insurance planning which **identifies the needs of an individual and the individual's dependents.** This approach determines the total funds available to a family from all sources and subtracts the amount needed to meet their financial objectives. It takes into consideration:

- **Final Expense Fund**
- **Housing Fund**
- **Education Fund**

- **Monthly Income**
- **Emergency Fund**
- **Income Needs if Disabled or Ill**
- **Retirement Income**
- **Estate Conservation (using life insurance to enable heirs to pay estate taxes)**
- *NEEDS include ANY(ONE or THING) depending on that person, charity, child, pet,*

►The needs approach to personal life insurance planning may involve creating a lump sum to provide for such things as education, retirement, and charitable

►The needs approach to personal life insurance planning also includes the creation of an emergency reserve fund. This fund is designed primarily to cover the cost of unexpected expenses.

►The "needs approach" in life insurance is most useful in determining how much life insurance a client
should apply for.

➢ BUSINESS USES OF LIFE INSURANCE

Buy-Sell agreements are also known as business continuation agreements and are used to assure the ownership of the business is properly transferred upon the death or disability of an owner or partner. **Third-party ownership of life insurance policies is widely used in business insurance and estate-planning situations.**

Buy-Sell Funding for Sole Proprietors
There is a two-step business continuation plan to keep the business running after the proprietor's death, whereby the employee takes over management of the business:

- **Buy-Sell Plan:** an attorney drafts a buy-sell plan stating the employee's agreement to purchase the proprietor's estate and sell the business at a price that has been agreed-upon beforehand.

- **Insurance Policy:** the employee purchases a life insurance policy on the life of the proprietor. The employee is the policyowner, beneficiary, and pays the premiums. Upon the proprietor's death, the funds from the policy are used to buy the business.

Buy-Sell Funding for Partnerships

There are two types of buy-sell agreements for partnerships: cross-purchase plans and entity plans.

Cross-purchase plans: In a cross-purchase plan, each partner buys, pays the premiums, and is the beneficiary of a life insurance policy on each of the other partners. The amount of the policy is equivalent to each partner's share of the business. When one partner dies, each of the other partners receives the death benefit from the life insurance on the

deceased partner, which is then used to buy the deceased partner's ownership of the business.

Entity plans: the partnership itself agrees to buy the deceased partner's share of the business.
Entity plans are best for businesses with several partners. In this case, the business purchases, pays the premiums and is the beneficiary of life insurance on each partner.

Buy-Sell Funding for Close Corporations
Unlike a partnership, a close corporation (i.e. an incorporated family business) is legally separate from its owners. It exists after one or more owners dies. A close corporation may purchase either buy-sell plans: cross-purchase or entity. The difference is that an entity plan is termed a *stock redemption plan* for close corporations.

Close Corporation Cross-Purchase Plan
Similar to partnership cross-purchase plans, a close corporation cross-purchase plan requires surviving stockholders purchase the deceased stockholder's interest in the company, and the deceased stockholder's estate sell the interest to the surviving stockholders. The corporation is not part of the buy-sell plan. Each stockholder owns, pays the premiums and is the beneficiary of life insurance on each of the other stockholders in an amount equal to his share of the corporation's purchase price.

Close Corporation Stock Redemption Plan
Similar to the partnership entity plan, the corporation purchases, is the owner, pays the premiums and is the beneficiary of life insurance policies on each stockholder. The amount of life insurance is equal to each stockholder's share of the corporation's purchase price. When a stockholder dies, the corporation purchases, or redeems, the deceased stockholder's share.

Key Person Insurance: The purpose of key person insurance is to prevent the financial loss that may ensue when an owner, officer or manager dies.

- It pays for finding and training a replacement if the key employee dies prematurely
- The company purchases, owns, pays the premiums and is the beneficiary of the life insurance policy on the key person.
- The premiums are not deductible for income purposes. However, the death proceeds received by the business are not taxable.

➢ EMPLOYEE BENEFIT PLANS

Deferred Compensation: is an executive benefit an employer can use to pay a highly paid employee at a later date, such as upon disability, retirement or death.

Salary Continuation Plan: works the same as deferred compensation except that the employer funds the plan rather than the employee. The employer establishes an

agreement, whereby an employee will continue to receive income payments upon death, disability or retirement.

Split-Dollar Plan: is an arrangement where an employer and an employee share in the cost of purchasing a life insurance policy on the employee. It is a method of buying insurance, not an insurance policy itself. Many times it is a combination of term and whole life insurance.

Florida General Laws

➢ Office of Insurance Regulation

The mission of the Office of Insurance Regulation is to promote the public welfare by maintaining the solvency of insurance companies.

Note: The Office of Insurance Regulation has primary responsibility for regulation, compliance and enforcement of statutes related to the business of insurance and the monitoring of industry markets.

- The insurance policy forms used in Florida are approved by the **Office of Insurance Regulation (OIR)**

Insurance laws in Florida are administered by the Chief Financial Officer, the Financial Services Commission and the Commissioner of the Office of Insurance Regulation. The Chief Financial Officer (CFO) is independently elected and serves as the head of the Department of Financial Services. Although commissioners are sometimes elected, they are mainly appointed by the governor.

Bureau of Unclaimed Property
The **Chief Financial Officer** oversees the Bureau of Unclaimed Property, which holds unclaimed property accounts valued at more than $1 Billion, mostly from dormant accounts in financial institutions, insurance and utility companies, securities and trust holdings.

Hearings
The Financial Services Commission may hold hearings for any purpose within the scope of the insurance code deemed necessary, such as:

- Person engaging in unfair competition, or any unfair or deceptive act
- Person engaging in business of insurance without a license
- The best interest of the public would be served

➢ Licensing

A licensee may **not** transact insurance business in Florida until the licensee is **appointed** by an insurer.

Individuals looking to acquire an insurance license must meet the following eligibility requirements:

- **Must be at least 18 years old**
- **Must be a US citizen or legal alien**
- **Must be a Florida resident**
- **May not be an employee of the United States Department of Veterans Affairs**
- **May not be a funeral director or direct disposer**
- **Complete a 40-Hour pre-licensing education course**
- **Pass the insurance state licensing examination**
- **Must be trustworthy and competent**

Continuing education

An agent needs to abide by the following guidelines every **two years** to maintain their license:

- **24 hours** of continuing education every two years for agents licensed **less than 6 years**
- **20 hours** of continuing education for every two years for agents licensed **more than 6 years**
- **Any continuing education must include a minimum 5 hours in ethics**
- Pay license fees, appointment and renewal fee
- Continue to be **appointed** with an insurance company

Suspension, termination, revoking of a license

The Chief Financial Officer has the power to suspend or revoke the license of an insurance agent who violates the Insurance Code. In lieu of suspension or revocation, the CFO has the authority to issue fines or order probation.

There are a number of situations where the Chief Financial Officer (CFO) can impose penalties or suspend, terminate, or revoke a license:

- Failure to answer a subpoena or an order of the CFO can result in a $1,000 fine
- Violation of a cease and desist order can result in a fine up to $50,000
- Willful violation of the Insurance Code is a misdemeanor
- Willfully submitting fraudulent signatures on an application or policy- related document is a third degree felony and is subject to a $5,000 to $75,000 fine for each violation
- In the event someone breaks an insurance law for which there is no definable penalty, one can be charged $5,000 for the first offense and $10,000 for every subsequent offense
- Provided incorrect, misleading, incomplete or untrue information in the license application
- Violating any insurance laws, regulations, subpoena, or orders from the Commissioner
- Attempting to obtain a license through fraud or misrepresentation
- Obtaining to obtain a license through fraud or misrepresentation
- Intentionally misrepresent the terms of an insurance contract
- Been convicted of a felony
- Committed any insurance unfair trade practice
- Using fraudulent, coercive, or dishonest practices or demonstrating incompetence, untrustworthiness, or financial irresponsibility in this or any other state.
- Having an insurance license denied, suspended, or revoked by another state
- Forging a name to an insurance document or application
- Cheating on an insurance license examination
- Knowingly accepting insurance business from an unlicensed individual
- Failing to comply with a court order imposing child support
- Failing to pay state income tax
- Obtaining license for the purpose of writing controlled business
- An agent's license will terminate if the agent allows **48 months** to elapse without being appointed for the class or classes of insurance listed on the license

➢ Agents and Agencies

Agent
An agent is an individual who has been authorized by an insurer to be its representative and to perform all of the following acts:

- Solicit applications for insurance
- Collect premiums from policyowners
- Render services to prospects and clients
- Field underwriting if necessary

Appointment
The authority given to an agent to transact business on behalf of the insurer is called **appointment.**

Change of address
If an agent changes his/her residence address, the Department of Financial Services must be notified within **30 days.**

Reporting of actions
If an agent is found guilty of a felony, he/she is required to notify the Department of Insurance within **30 days.**

Agencies

- An insurance agency is any business location where insurance transactions take place that can only be performed by licensed insurance agents
- There must be an **agent in charge** at each licensed agency location where insurance transactions take place
- A licensed insurance agent may be the agent in charge of additional branch office locations of the agency as long as insurance activities **do not** occur at any location when the agent is **not physically present**

Home agencies
The Department of Financial Services considers all of these factors when determining whether an agent's home is an insurance agency:

- Listing the location address on business cards/marketing materials and solicits business to be done at that location
- There is a sign on the house indicating an agent is there
- The agent meets clients there
- Insurance transactions take place at the location

Professional Employer Organization
A Professional Employer Organization typically handles only **administration functions**.

➢ Certificate of Authority

Before an insurance company can sell insurance in a specific state, they must apply for a license or Certificate of Authority from that state's Department of Insurance. Once approved and given a Certificate of Authority, they are eligible to transact insurance.

➢ Insurance Transaction

"Insurance Transaction" includes any of the following:

- **Solicitation or inducement to purchase insurance**
- **Negotiations toward the sale of insurance**
- **Executing a contract of insurance**
- **Issuing an insurance contract**
- **Advising on coverages and claims**

A licensee may **not** transact insurance business in Florida until the licensee is **appointed** by an insurer.

The agent's primary responsibility in the application process is to the **insurer**.

➢ Unfair Trade Practices

Twisting
Twisting occurs when an insurance agent convinces a policyowner to cancel their current policy so that they can purchase new life insurance policy with another company. This would involve the agent using misrepresentations or incomplete comparisons of the advantages and disadvantages of the two policies. Twisting is a form of misrepresentation and is illegal.

Churning **Churning occurs when an agent has a policyholder replace one policy for another with the same company for the sole purpose of making more commission. This can involve using the cash value and/or dividends of an existing policy to purchase another policy with the same insurer.** This normally is done using misrepresentation or deception and is not in the policyholder's bestinterest.

Note: Agents who use **twisting or churning** can be charged with a first degree misdemeanor and a fine from $5,000 to $75,000 for each violation

Sliding **Sliding occurs when an agent tells an applicant that in order to get the product they want, they are required by law to get an additional product as well**. It can also mean **falsely representing to an applicant that specific coverage is included in the policy applied for with no additionalcharge.**

Coercion
Coercion is when an agent uses physical or mental force, with the intent of convincing an applicant to buy insurance.

Misrepresentation
Misrepresentation is when an agent **uses publications, sales materials, or makes statements that are false, misleading, or deceptive to unfairly influence the purchase of a policy.**

- **An example of misrepresentation would be when an agent tells a client that dividends are guaranteed**

Defamation
Defamation occurs when an oral or written statement is maliciously made that is **intended to injure a person in the insurance business or be critical and misleading about the financial condition of a person or company.**

Fraud
Fraud occurs when someone intentionally deceives another with the intent to gain financially.

Unfair discrimination
It is an illegal practice to unfairly discriminate against a person in any way on an insurance-related matter. An example would be providing different terms of coverage for different policyowners in the same risk classification. Fair discrimination is necessary for the issuance of life insurance policies, which is based on mortality.

Controlled Business
Controlled business is coverage written by an agent on his/her own life, health, property, immediate family, or business associates. Most states will not issue a license to a person if it is determined that their primary purpose is to write controlled business.

Note: Normally no more than **50%** of an agent's insurance sales are allowed to come from controlled business

Rebating
Rebating happens when an agent refunds part of their commission, or exchanges anything of value to induce someone to purchase an insurance policy. Rebating is allowed in Florida **if the agent rebates insureds in the same actuarial class.**

False advertising It is an illegal practice to falsely advertise insurance products **or publish misleading information about its insurance coverage.** This includes making false statements about the financial condition of an insurer.

- An insurer exaggerating its dividends in a publication is also considered a form of false advertising

➢ Unfair Claims Settlement

The following acts, omissions, or practices are defined as unfair and deceptive claim settlement practices when knowingly committed or performed with such frequency as to indicate a general business practice, and are prohibited:

- **Misrepresenting to insured's pertinent facts or policy provisions relating to coverage at issue**
- **Failing to acknowledge and act reasonably promptly upon communications with respect to an insurance claim**
- **Failing to adopt and implement reasonable standards for prompt investigation and processing of insured's claims**
- **Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements are completed and submitted by insured's**
- **Not attempting in good faith to effect prompt, fair and equitable settlements of claims on which liability has become reasonably clear; Refusing or delaying a settlement solely because there is other insurance available to partially or entirely satisfy the claim loss; the claimant who has a right to recover from more than one insurer has the right to choose the coverage from which to recover and the order in which payment is to be made**
- **Compelling insured's to initiate suits to recover amounts due under an insurance policy by offering substantially less than the amount ultimately recovered in those suits**

Domestic, Foreign, and Alien Companies

Insurance companies are classified according to the location of its corporation. Regardless of where the insurance company is incorporated, it still has to get a Certificate of Authority before transacting insurance within a state.

The following definitions apply:

Domestic insurance company: A company that **resides and is incorporated under the laws of the state in which its home office is located.**

Company chartered in Florida would be a domestic company in Florida.

Foreign insurance company: A company whose **home office is located in another state.** It is considered to be a foreign company in all states except for its home state.

Company chartered in Texas would be a foreign company in Florida.

Alien insurance company: is one that is **chartered and organized in any country other than the United States**. It is considered an alien insurance company in all states.

Company chartered in Canada would be an alien company in Florida.

Authorized, Unauthorized, and Eligible Companies

Authorized insurer: An insurance company that has qualified and received a Certificate of Authority from the Department of Insurance (or sometimes called Department of Financial Services) to sell insurance in that state.

- Also called an admitted insurance company

Unauthorized Insurer: An insurance company that has been denied or not yet applied for a Certificate of Authority and may not sell insurance in that state.

- Also called a non-admitted insurance company
- Possible consequences for placing with an unauthorized insurer include: conviction of a third degree felony, liability for all unpaid claims, and revocation of all insurance licenses

Stock and Mutual Companies

Stock Insurance Company: An insurance company that is owned and controlled by stockholders (shareholders). The stockholders provide the capital and share in profits or losses.

- Stock Insurance Companies are considered **Non-participating or Non-par** because the policyowners do not share in the profits of the company
- Their objective is to produce a profit for its owners, the stockholders
- Stock Insurance Companies that issues both participating and non-participating policies are referred to as a company doing business on a **mixed plan**

Mutual life insurance companies: are owned and controlled by its policyowners. These policyholders elect a board of trustees or directors to manage the firm. The profits of a mutual insurance company are returned to the policy owners in the form of dividends or retained as surplus to meet future obligations.

- Mutual Insurance Companies are considered **Participating or Par** because the policyowners do share in the profits of the company
- Objective is to provide insurance to its owners, the policyowners, at the lowest possible net cost

➢ **Advertising**

Advertisement may include any method of communication

- In a newspaper, magazine, or other publication
- In the form of a notice, circular, pamphlet, letter, or poster
- Over any radio or television

Advertisement does not include

- Material used solely for the training and education of an insurer's employees, agents, or brokers
- Internal communication within an insurer's own organization
- Correspondence between a prospective group or blanket policyholder and an insurer during negotiations

Testimonials

Testimonials and endorsements used in advertisements must be genuine and represent the current opinion of the author.

Disparaging comparisons and statements

An advertisement must not directly or indirectly make unfair or incomplete comparisons of policies, contracts, or benefits.

Identity of insurer

The name of the actual insurer must be stated in all of the insurer's advertisements. The form number or numbers of the policy advertised must be stated in any invitation to contract. An advertisement must not use a trade name, name of the parent company of the insurer, or any other device that would be misleading to the true identity of the actual insurer.

Statement about an insurer

An advertisement must not contain statements that are untrue or misleading with respect to the assets, corporate structure, financial standing, age, or relative position of the insurer.

Advertising file

Each insurer must maintain at its home office a complete file of its advertising materials, available for inspection, for a period of 4 years.

Gifts

An agent is allowed to give advertising gifts to a prospective customer, provided they do not exceed $25.

➢ Florida Life and Health Insurance Guaranty Association

The Florida Life and Health Insurance Guaranty Association was established to provide funds **to protect an insured in the event of an insurer's insolvency.**

- **The Life and Health Guaranty Association is funded by insurance companies through assessments**
- Agents are prohibited from using the existence of the Life and Health Guaranty Association for selling, soliciting, or inducing purchase of an insurance policy

➢ Code of Ethics

Agent Ethics

Trade practices: The life insurance industry has been declared to be a public trust in which service of all agents of all companies have a common obligation to work together in serving the best interest of the insuring public.

Note: The Code of Ethics specifically forbids agents or companies to engage in any act of twisting, rebating, defamation, or misrepresentation.

Fiduciary responsibility: An agent must handle funds of a client or insurance company honestly and fairly and NOT use them for the agent's own purposes.

Licensed Agents: Agents may not submit applications to an insurer unless the name of the insurer is legibly typed or printed on the first page of the application at the time coverage is bound or the premium is quoted. The application must also disclose the name and license identification number of the agent as shown on the agent's license. This information must be legibly typed, printed, stamped, or written. A copy of the completed application must be provided to the prospective insured.

Every insurance policy issued in the state of Florida must specify the following:

- **The names of the parties to the contract**
- **The subject of the insurance**
- **The risks insured against**
- **The effective date and period of coverage**
- **The premium**
- **The conditions pertaining to the insurance**
- **The form numbers and edition dates of all endorsements attached to the policy**

National Association of Insurance and Financial Advisors (NAIFA)
The National Association of Insurance and Financial Advisors is a **professional organization whose code of ethics is incorporated into Florida law and whose responsibility it is to establish the activities of agents.**

Florida Life Laws

Rules of disclosure

The **"rules of disclosure"** review what needs to be provided to each prospective purchaser of a life insurance policy. This includes **a buyer's guide, policy summary, and 14 day free-look period.**

Minimum age

The minimum age at which an individual can sign a life insurance application is **15 years.**

Contestable period

A provision that the policy terms shall be incontestable after it has been in force for a period of **2 years** from its date of issue (unless the purpose for taking out the coverage was **fraud**).

Free-look period

Free Look provision allows an insured a period of **14 days** from the delivery date of the policy to look over the new policy and return it for a full premium refund if dissatisfied for any reason.

Note: the 14 day period begins when the applicant receives the policy in **the mail or is delivered by an agent.**

Buyer's guide

Buyer's Guide provides basic information about an insurance policy. This document explains how a buyer should go about choosing the amount and type of insurance to buy, and how a buyer can save money by comparing the cost of similar policies.

Note: The insurer must provide **a buyer's guide** along with **a policy summary** to any prospective purchaser before accepting the applicant's initial premium or upon the applicant's request.

Grace Period

Life insurance policies must provide a grace period of 30 days after the due date. If the insured dies during the grace period, the insurance company may deduct any premium due from the death benefit.

Interest Rates

The maximum fixed policy loan interest rate that an insurer can charge in Florida is 10%. Adjustable rates for policy loans are based on **Moody's corporate bond index.**

Named Beneficiary

In Florida, if a policy is made payable to a named beneficiary, a creditor can make no claim on the proceeds.

Senior Citizen Grace Periods
In Florida, anyone **over the age of 64** will **receive an additional 21 days beyond the normal policy grace**

period. Suicide

Clause

In Florida, if an insured commits suicide **within 2 years** of policy issue, the beneficiary will only receive a refund of premiums paid. After two years, the face amount will be paid in the event of suicide.

Industrial Policies When an

insured has industrial life insurance policies with a single insurance company that total $3,000 or more in face value, the insured has the option to convert all of these policies into one ordinary life insurance policy at standard premium without evidence of insurability.

Reinstatement

An insurance company that requires an application for reinstatement has **45 days** to reject the application before reinstatement is automatic. In other words, if the insurer takes no action within 45 days, the policy is considered reinstated automatically.

Excess Business

Under Florida law, **"excess business"** is permitted when **an agent's own company is not able to write the amount of insurance requested by the applicant.** Excess business is that portion of a risk above the limits of that which the agent's own insurer will accept. A licensed life agent may place excess or rejected risks with any other authorized insurer without being required to secure an appointment as to such other insurer.

Excess Charges

Excess charges occur when an agent knowingly collects money for a premium or an additional charge for insurance that is not provided for in the policy.

ERISA

ERISA supersedes Florida state law relating to employee retirement plans. The savings clause in ERISA protects the following areas of state regulation:

- **Insurance**
- **Banking**
- **Securities**

Agent Responsibilities

While life insurance agents should be generally familiar with all Florida insurance regulations, the following 3 are of particular importance:

- **The Solicitation Law:** spells out the information and procedures required of agents and insurers when proposing life insurance to a prospective buyer;
- **Replacement Rule:** sets forth the requirements and procedures to be followed by insurance companies and agents when a proposal is being made in which a prospective life insurance buyer will be replacing existing insurance contracts with the proposed new insurance
- **Code of Ethics:** establishes a broad outline defining appropriate and inappropriate business behavior for life insurance agents.

➢ Replacement

Replacement

Replacement is strictly regulated and requires full disclosure by both the agent and the replacing insurance company. Replacement regulations exists to assure that purchasers receive specified information and it also reduces the opportunity for misrepresentation. Policy replacement is defined as a transaction in which a new policy or contract is to be purchased, and the agent is aware that an existing policy or contract has been, or will be:

- Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated
- Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values
- Modified to cause a reduction in benefits or length of policy term
- Subjected to loans exceeding **25% of the cash value**
- Reissued with a reduction in cash value
- Used in a financed purchase

Duties of the replacing agent

- Present to the applicant a **Notice Regarding Replacement** that is signed by both the applicant and the agent. A copy must be left with the applicant.
- Obtain a list of all existing life insurance and/or annuity policies to be replaced including policy numbers and the names of all companies being replaced.
- Leave the applicant with the original or a copy of written or printed communications used for presentation to the applicant.
- Submit to the **replacing insurance company** a copy of the Replacement Notice with the application.
- An agent must disclose the possible tax consequences of replacing or exchanging an existing annuity or life insurance policy.

Duties of the replacing insurance company

- Require from the agent a list of the applicant's life insurance or annuity contracts to be replaced and a copy of the replacement notice provided to the applicant.
- Send each existing insurance company a written communication advising of the proposed replacement within a specified period of time of the date that the application is received in the replacing insurance company's home or regional office. A policy summary or ledger statement containing policy data on the proposed life insurance or annuity must be included.

The replacement of existing life insurance policies with new contracts of life insurance requires a written Comparison and Summary Statement at the **policyowner's request**.

Conservation

An agent's attempt to stop the replacement of an existing life insurance policy or annuity is known as conservation.

➢ Group Life Insurance

Certificate

Instead of a policy, the participants under a group plan are issued **certificates of insurance** as evidence that they have coverage.

- Each person insured under a Group Life insurance policy is a certificate holder

The certificate must contain the following information:

- **Group policy number**
- **Description of insurance protection to which the certificate-holder is entitled**
- **The name of the insured, beneficiaries and dependents (if any)**
- **The rights and conditions**

Conversion

In Florida, group life policies must contain a conversion privilege that allows for conversion to an individual policy for a specified period of time.

- **Converted individual policies do not require evidence of insurability**

Eligibility

Participants are given a period of time, known as the **eligibility period**, to join the group plan. Other plans use an open enrollment period, in which case all new employees must wait until the next enrollment period before joining the group plan. **In Florida, there is no minimum number of insureds required for a group life insurance policy.**

Note: Those who do not enroll at the first opportunity can be required to provide evidence of insurability

Group life statutes

- The employees eligible for group insurance under the policy shall be all of the employees of the employer.
- In the event of a termination of a group life plan or termination of a covered employee, a person covered by a group policy has the right to convert such coverage to an individual policy within **the conversion period (31 days)** without proving insurability. If this right is exercised, the employee is responsible for the payment of premium.
- There are **no restrictions** regarding the assignment of coverage under a group life insurance policy

Cancellation

An insurer must notify each certificate holder (employee) when the master policy has expired or is being cancelled.

- 13 The insurer may take such action through the policyholder (employer)

Fraternal life insurance organizations

Fraternal life insurance organizations are nonprofit providers of life insurance that is covered by a special section of the Florida insurance code.

Entities

The following entities for selling life insurance are legal in the State of Florida

- Personal producing general agencies
- Independent agency systems
- Career agency systems

Eligibility requirements for associations

The following are the eligibility requirements for an association to purchase life insurance for its members on a group basis:

- The group must be a natural group (organized for some reason other than to obtain group insurance)
- A minimum of 100 participants is required for a contributory plan
- The group must have been in existence for two years
- The group must hold regular meetings at least on an annual basis

Noncontributory group

In a noncontributory group, the policy must cover **100% of eligible persons**.

➢ Viatical Settlements

Allows someone with a terminal illness to sell their existing life insurance policy to a third party for a percentage of the face value. To receive a percentage of the policy face value, an owner of a life policy may sell the policy to a **viatical settlement provider.** The new owner continues to make the premium payments and will eventually collect the entire death benefit. Viatical settlement brokers must be licensed before conducting any viatical transactions. **Proceeds of the viatical settlement contract could be subject to the claims of creditors.**

Note: the original policy owner is called the Viator and the new third party owner is called the Viatical or sometimes called the Viatee. **A viatical settlement broker can advertise the availability of viatical settlements, introduce viators to viatical settlement providers, and charge a fee for their services.**

➢ Variable Products

- An agent who wants to sell Variable annuities must be licensed by the state, which includes examinations in Life and Variable contracts.
- Agents marketing variable life insurance must be licensed and appointed as a life and variable

contract agent, and a **broker dealer**

- Variable annuities are regulated by both the **Department of Financial Services and the Securities Exchange Commission**
- A variable annuity policyholder must be informed of the accumulated value of the contract during the premium payment period **at least once each year**

➢ Suitability in Annuity Transactions

Standards and procedures are in existence to ensure that anyone looking to purchase, exchange, or replace an annuity is properly informed and the recommendations given to them are in their best interests. The intended goal of this regulation is a consumer who has had their insurance needs and financial objectives properly addressed.

The following list is information that should be taken into consideration when making suitable recommendations concerning the purchase, exchange, or replacement of an annuity:

- Age
- Annual income
- Financial situation and needs
- Financial experience
- Financial objectives
- Intended use of the annuity
- Financial time horizon
- Existing assets
- Liquidity needs
- Net worth
- Risk tolerance
- Tax status
- Present income

Florida Health Laws

➢ Required provisions

Entire contract

A provision that the **policy, application, and all attachments** shall constitute the entire contract between the parties.

- **States that the agent does NOT have the authority to change the policy or waive any of its provisions**

Time limit on certain defenses (Incontestable Period)

A health or disability policy is incontestable after it has been in force for a period of **2 years.** Only fraudulent misstatements in the application may be used to void the policy or deny any claim at this point.

Grace Period

The grace period for health and accident insurance is required to be no less than 7 days for weekly premium policies, 10 days for monthly premium policies and, 31 days for all other policies. If premium is paid within the grace period, coverage shall remain in effect.

Reinstatement

If a health policy is reinstated after it had lapsed for nonpayment, there is a waiting period of **10 days** before a claim covering sickness will be covered. Injuries sustained from an accident, however, will be covered immediately.

- If the insurer takes no action within **45 days** after receiving the reinstatement application, the policy is considered automatically reinstated

Notice of claim

Written notice of a claim must be given within **20 days** after a covered loss starts or as soon as reasonably possible.

Claim forms

An insurance company will send forms for filing proof of loss to a claimant within **15 days** after company receives notice of a claim.

Proof of loss

Written proof for any loss must be given to the insurance company within **90 days**.

Time payment of claims

The time payment of claims provision allows insurers **45 days** after receiving notice and proof of loss in which to pay or deny the claim.

- The minimum schedule of time in which claims MUST be made to an insured under an Individual Disability policy is **monthly**

Right to examine (free-look)

Health insurance policies must provide a minimum free-look period of **10 days** upon policy delivery. This allows the policyowner time to decide whether or not to keep it. If the policyowner decides not to keep the policy within the 10 days allowed, a full refund will be given.

- A person who is eligible for Medicare has a free-look period of 30 days

Legal Actions

No legal action can be initiated within **60 days** after proof of loss has been submitted to the insurance company. In addition, no legal action can be initiated after **5 years** from the initial time written proof of loss has been provided.

Advertisements

- All advertisements for health insurance shall make clear the identity of the insurer
- Insurance companies are responsible for the accuracy of testimonials

Physical Exams and Autopsies

The insurer has the right to examine the insured during the claim process and to an autopsy when death is involved and where it is not forbidden by law.

Illegal occupation

The insurer shall not be liable for any loss to which a contributing cause was the insured being engaged in a felony or illegal occupation.

Change of beneficiary

The change of beneficiary provision allows the policyowner to change the policy beneficiary if so desired as long as the beneficiary designation is revocable. This provision also gives the policyowner the right to surrender or assign the policy without obtaining the beneficiary's permission.

➢ Pre-existing conditions

Individual health insurance

Florida law prohibits individual health insurance policies (other than disability income insurance) from excluding coverage for preexisting conditions for longer than 24 months following the effective date of coverage, based upon a condition that had manifested itself during the previous 24-month period in such a manner as would cause an ordinarily prudent person to seek medical advice or treatment.

Group health insurance

For group health insurance: Pre-existing conditions (conditions for which medical advice, diagnosis, care or treatment was recommended or received in the **6 months prior** to the effective date of enrollment) may be excluded for a maximum of **12 months** from the date of enrollment **(18 months for late enrollees)**. Creditable coverage will be used to reduce the exclusion period, unless the individual has a coverage gap of 63 days prior to enrollment in the group plan.

- The underwriting and issuance of a master group health policy in Florida requires that all employees or members must be eligible to participate regardless of individual health history

Replacement health insurance

When a person covered by a health insurance plan moves to another plan, any credit toward fulfilling the preexisting requirement on the prior plan will be transferred to the new plan.

Pre-existing conditions, replacement policies

When replacing an individual health policy in Florida, the required replacement notice to the applicant must include **notice that pre-existing conditions may not be covered.**

An individual's waiting period for pre-existing conditions is reduced when he or she has "creditable coverage." Creditable coverage is previous coverage under another group or individual health plan when there has not been a break in coverage of **63 days**. The 63-day period begins when the individual's previous coverage ended. It ends when coverage under your plan begins, or, if earlier, when your group's waiting period for eligibility begins.

Under HIPAA requirements **18 months** of "creditable coverage" are required in order for a person who does not have access to other health insurance to be given the opportunity to purchase an individual health insurance policy

➢ Florida Eligibility Requirements and Offers

Newborn child coverage

All health plans that provide coverage to family members of the insured, must provide coverage for the insured's newborn child from **the moment of birth** for a period of **18 months.**

Handicapped children

In Florida, coverage for a child who is dependent on the parents for support due to a physical handicap may be continued beyond the contractual limiting age when **the child is incapable of self sustaining employment.**

Adopted and prospective adopted children

All health plans must provide coverage to the insured's adopted children on the same basis as other dependents.

Substance abuse

All health plans must provide benefits when an insured is confined for treatment of alcoholism or drug abuse in a licensed medical care facility.

Mental Health

All health plans must provide benefits when an insured is confined for in-patient treatment of mental illness in a licensed medical care facility.

Converted policies

At the option of the insurer, a separate converted policy may be issued to cover a dependent.

Genetic testing

The use of genetic information or test results by health insurers or HMO's is prohibited.

Definition of small employer

A small employer is one that employs not more than 50 employees

When offering a health benefit plan to small employers, the carrier MUST offer **at least the standard plan**

- A small employer carrier that offers health coverage in the small employer group market shall renew or continue in force that plan at the option of the small employer

Exclusive Provider Organization

A provider that has entered into a written agreement with a health insurance company to provide health care services for certain insureds. It can offer these services through its own facilities or a network of health care professionals, or it may use another facility, such as an HMO.

Dread disease policies

Dread Disease policies cover a single disease or illness only.

Discount Medical Plan

An arrangement or contract in which a person, in exchange for fees or other consideration, provides access for plan members to the services of providers of medical services at a discount.

Contributory group plan

Under Florida law, there is **no specific minimum percentage participation** for employees covered by employee group health insurance.

Coordination of benefits (COB)

The purpose of the coordination of benefits (COB) provision, found only in group health plans, is to avoid duplication of benefit payments.

Association plans

Association Plans **must be fully insured by an authorized insurer**, so the insurer is subject to state regulation.

Prepaid Limited Health Service Organization (PLHSO)

A PLHSO is any person, corporation, partnership, or any other entity that, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers for the following services:

- Ambulance services
- Dental care services
- Vision care services
- Mental health services
- Substance abuse services
- Chiropractic services
- Podiatric care services
- Pharmaceutical services

➢ COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires employers with 20 or more employees to include a continuation of benefits provision for former employees and their dependents. COBRA guarantees that the participant can continue the group coverage (at their own expense) at group rates if their participation in the group plan is terminated because of a qualifying event.

Qualifying events: include the death of the employee, termination of employment (except for termination because of gross misconduct) or a reduction in work hours, which results in the participant no longer qualifying for group coverage.

Note: It is important to remember that COBRA benefits apply only to group health insurance, not group life insurance.

Continuation of group coverage

Employees who have been covered under a group health plan for at least **3 months** before their termination to be eligible to continue their coverage under COBRA. They must request continuation within **31 days** following termination.

Mini COBRA

Florida's Health Insurance Coverage Continuation Act (Mini COBRA) applies to employers who employ less than 20 employees.

➢ Florida Employee Health Care Access Act

The purpose of the Florida Employee Health Care Access Act is to **make group health insurance available to employers with 50 or fewer employees.**

- The provisions of the Florida Employee Health Care Access Act require that **all small group health benefit plans be issued on a "guaranteed-issue" basis**

➢ Florida Healthy Kids Corporation

Florida Healthy Kids offers health insurance for children ages 5-18. Health Kids is designed to provide quality, affordable health insurance for families not eligible for Medicaid.

- Families with children covered by the Florida Healthy Kids Corporation program pay only a **portion of the premium**

➢ Long-Term Care

Definition

Long-term care insurance is designed to provide coverage for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services in a setting other than an acute care unit of a hospital.

- A health insurance agent license is required in order to solicit Long-term care insurance in the State of Florida
- Long-term care insurance is any policy designed to provide coverage for at least 12 consecutive

months for each covered person on an expense-incurred, indemnity, prepaid, or other basis

Notice to buyer

A **"notice to buyer"** must be on the first page of each long-term care policy delivered in. It explains that some long-term care costs may not be covered.

Outline of Coverage

An outline of coverage is required and provides a very brief description of the important features of the policy. It is considered a summary of coverage. It requires:

- A summary of the policy's principal exclusions and limitations
- A statement of the policy's renewal and cancellation provisions
- A description of the policy's principal benefits and coverage

Renewability Provision

Individual long-term care insurance policies shall contain an appropriately captioned renewability provision on the **first page of the policy form**.

- The renewability provision shall clearly state that the coverage is guaranteed renewable or noncancellable

Pre-existing Conditions

Pre-existing conditions are those for which medical advice or treatment was recommended by or received from a health provider within **six months** preceding the effective date of an individual long-term care policy.

Free look

A **30 day** free look period is required for long-term care policies.

Inflation Protection

All insurers issuing long-term care insurance policies must offer, as an optional benefit, **an inflation protection feature** which provides for automatic future increases in the level of benefits without evidence of insurability. Adjustments must be at a level which provides reasonable protection from future increases in the costs of care for which benefits are provided**.**

Lapse notice

An insurer must mail a long-term care lapse notice at least 30 days prior to the effective date of cancellation to both the policyholder and a specified secondary addressee.

Home Health Care

Long-term care policies must pay for "at-home" care at **the same daily amount as paid for a nursing home** if the insured meets the qualifications for nursing home care.

Limitations and Exclusions

Exclusion or limitation of benefits on the basis of Alzheimer's Disease is NOT permitted. However, limits

and exclusions may be placed on:

- Preexisting conditions or diseases
- Alcoholism and drug addiction
- War or acts of war
- Participation in a felony, riot or insurrection
- Suicide or self-inflicted injury
- Aviation (except for fare-paying passengers)

➢ Medicare Supplements

- Insurers must file with the Commissioner a copy of any Medicare supplement advertisement before it is to be used in Florida
- The marketing of Medicare Supplements is regulated to prevent sales of **excessive insurance**, **inaccurate policy comparisons**, and the **failure to display notice of limitations to the buyer**
- The **agent who solicits the application** is primarily responsible for determining the appropriateness of a Medicare supplement policy for a proposed insured
- Every agent soliciting Medicare Supplements must provide a **suitability form**
- To verify if replacement is involved in a Medicare Supplement sale, insurance law requires that a question about replacement appear on **the application form**
- If a Medicare Supplement policy is sold, the agent must deliver an Outline of Coverage to the applicant **no later than when the application is taken**
- When a Medicare supplement policy is purchased during the open enrollment period, the policy must be issued **regardless of health status**
- Free-look period for Medicare Supplements is **30 days**
- The open enrollment period for Medicare (and Medicare Supplements) begin **3 months before your 65th birthday** and lasts for 7 months
- An insurer may exclude coverage for a preexisting condition on a Medicare Supplement Policy for up to **6 months**.

➢ Prohibited Long-term care and Medicare Supplement Sales Practices

- **Twisting:** Using misrepresentations or inaccurate comparisons to induce a person to terminate or borrow against their current insurance policy to take out an insurance policy with another

insurer

- **High pressure tactics:** Used to induce the purchase of insurance through force, fright, threat, or undue pressure
- **Cold lead advertising:** Failing to disclose that the purpose of the marketing effort is insurance solicitation
- **Misrepresentation:** Misrepresenting a material fact in selling a long-term care insurance policy

➢ HMO Definitions

Member: A person who makes a contract or on whose behalf a contract is made with a health maintenance organization for health care services.

Provider: Any person, including a physician or hospital, who is licensed or otherwise authorized in this state to provide health care services.

Subscriber: A person who makes a contract with a health maintenance organization, either directly or through an insurer or marketing organization, under which the person or other designated persons are entitled to the health care services.

Individual contract: A contractual agreement for the provision of health care services on a prepaid basis entered into between an HMO and a subscriber covering the subscriber and the subscriber's dependents.

- An insurer may NOT issue an HMO contract

Every subscriber must receive a benefits package that includes a copy of the HMO contract and certificate and a member's handbook. The contract must contain all of the provisions required by law, such as:

- Must clearly state all services covered by contract
- Must state all limitations
- Enrollment
- Rates charged shall not be excessive
- Procedures for emergency treatment outside the HMO's geographic area
- Grace period of no less than 10 days
- Preexisting conditions in children may not be excluded
- Contract must be accompanied by an identification card
- Statement of time limit of certain defense clause (2 years) must be included
- Rate of payment must be clearly stated

➢ Dental

Restorative

Restorative dentistry is the procedure for restoring the function and integrity of a missing tooth structure. Examples include fillings, crowns, and dental bridges.

Oral surgery

Oral and maxillofacial surgery is surgery to treat many diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the oral and maxillofacial region.

Endodontics

Endodontics is the branch of dentistry dealing with diseases of the dental pulp. Root canals would be an example. Endodontics is commonly excluded or limited from a dental policy.

Periodontics

Periodontics is a dental specialty that involves the prevention, diagnosis and treatment of disease of the supporting and surrounding tissues of the teeth or their substitutes. It also involves the maintenance of the health, function, and esthetics of these structures or tissues.

Prosthodontics

Prosthodontics is a branch of dentistry dealing with the replacement of missing parts using biocompatible substitutes such as **bridgework or dentures**

Orthodontics

Orthodontics is the treatment of irregularities in the teeth (esp. of alignment and occlusion) and jaws, including the use of braces.

Dental Plans

Occasionally, dental insurance is part of a health benefits package with a single deductible called an integrated deductible, applying to both medical and dental coverages. More often, however, dental coverage and claims are handled separately with a separate deductible. There also may be a probationary period in group dental insurance to help hold down coverage for preexisting conditions. Some dental policies are scheduled, meaning benefits are **limited to specified maximums per procedure**, with first dollar coverage. Most, however, are comprehensive policies that work in much the same way as comprehensive medical expense coverage. In addition to deductibles, coinsurance and maximums may also affect the level of benefits payable under a dental plan.

Here are some other bullet points to consider when addressing dental plans:

- **A pre-treatment estimate** of the cost of dental services may be required whenever the patient

requires dental treatment

- Comprehensive dental plans usually provide routine dental care services without deductibles or coinsurance to encourage preventative care (such as teeth cleanings, fluoride treatments etc)
- Dental plans are typically indemnity plans, which pay benefits based on a predetermined, fixed rate set for the services provided…regardless of the actual expenses incurred.
- To prevent adverse selection in a group dental expense plan, the plan may require any of the following: **probationary periods, waiting periods, evidence of insurability, or limits on annual benefits**
- With prepaid dental plans, **coverage is limited to a closed panel of dentists**
- The absence of deductibles on routine examinations encourages preventive care in dental insurance
- Dental treatment expenses required to repair an injury would normally be covered under a hospital or medical expense policy.
- Some hospital and medical expense plans will provide coverage for some dental related services related to the jaw or facial bones. Some of these include: reduction of any facial bone fractures; removal of tumors; treatment of dislocations, facial and oral wounds/lacerations in order to repair an injury; and the removal of cysts or tumors of the jaws or facial bones.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA OR ACA)

Exchanges

- Created by the **Affordable Care Act (ACA)** health reform bill to help individuals and small businesses purchase health insurance coverage.
- The purposes of the exchange include:
  - Reduce the number of uninsured in the state
  - Facilitate the purchase and sale of qualified health plans in the individual market
  - Assist qualified employers in the state in enrolling their employees in qualified health plans
  - Assists individuals in accessing public programs, premium tax credits, and cost-sharing reductions
- Under the Affordable Care Act (ACA), the health insurance exchange will perform all of the following roles:
  - Certify health plans as qualified, based on pre-determined criteria
  - Utilize individual, unique formats for presenting health benefit plan options
  - Verify and resolve inconsistent information provided to the exchange by applicants

Essential health benefits

Beginning January 1, 2014, the exchange shall allow any qualified plans that meet the minimum standards established by the exchange to be offered in the exchange. All plans must include the following:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Metal levels

There are four tiers of "qualifying health plans" you or your employer can purchase on the exchange. They range from lower quality, but more affordable "Bronze plans", to "Silver plans" to a more expensive plan with better coverage called a "Gold plan". There is also a "Platinum plan" which is the highest quality and cost plan. Lower premium plans will have higher deductibles, less benefits and larger out of pocket costs. The actuarial level is calculated as the percentage of total average cost for covered benefits that a plan will cover.

- Bronze Plans: 60% actuarial level of coverage provided
- Silver Plans: 70% actuarial level of coverage provided
- Gold Plans: 80% actuarial level of coverage provided
- Platinum Plans: 90% actuarial level of coverage provided

Preexisting conditions

Health plans cannot limit or deny benefits or deny coverage for a child younger than age 19 because of preexisting conditions. This applies to both group and individual policies

Lifetime and annual limits

The ACA prohibits health plans from putting lifetime dollar limits on most benefits that are received by an insured.

- For plans starting on or after September 23, 2012, but not before January 1, 2014, the annual dollar limit is $2 million. After January 1, 2014, there are no annual dollar limits
- Plans are allowed to put an annual dollar limit on health care services that are not considered essential

Grandfathered Plans

- Grandfathered plans are plans that were purchased before March 23, 2010. These plans do not have to follow the ACA's rules and regulations or offer the same benefits, rights and protections as new plans.
- An exception to this is a grandfathered plan cannot impose lifetime limits on how much health care coverage people may receive
- Grandfathered health plans may lose their grandfathered status if the insurer significantly raises coinsurance charges, deductibles, or co-payment charges.

Other ACA requirements

- As defined by the Affordable Care Act, the MAXIMUM amount an individual can contribute to a Flexible Savings Account is $2,500
- Under the Affordable Care Act (ACA), parents can insure their dependent adult children up to their 26th birthday, even if they are married or not living with their parents
- Low-income individuals and families whose incomes are between 100% and 400% of the federal poverty level will receive federal subsidies on a sliding scale if they purchase insurance via an exchange
- Beginning January 1, 2014, the Patient Protection and Affordable Care Act (ACA) will require adjusted community rating in the **small group market**. Small group health plans will be allowed to vary rates only **based on whether the policy covers an individual or family, geographic area, age, and tobacco use**
- If an insurer fails to adhere to the Affordable Care Act requirements related to internal appeals, **the internal appeal may be deemed exhausted for purposes of submitting an external review**
- According to the Affordable Care Act, if a large employer does NOT provide health insurance and owes an employer mandate penalty, the annual penalty is calculated by **multiplying $2,000 by the number of full time employees minus 30**
- On or after January 1, 2014, employers with no more than 25 full time equivalent (FTE's) with average annual wages of less than $50,000 may be eligible for a tax credit of up to 50% of the premiums paid by the employer
- You may qualify for employer health care tax credits through SHOP if you have fewer than 25 full-time employees making an average of about $50,000 a year or less