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# LIFE-ONLY
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# Section LO 1

# Introduction To Life Insurance

**Objectives . . .**

We will define what exactly Life insurance is (and what it is not) and how it helps those who own it. Later we will delve into the "need" for life insurance and why people buy. The information will help you provide a valuable service to your customers, as well as deepen your knowledge and appreciation of the benefits of Life Insurance.

## Defining Life Insurance

### 1. What is Life Insurance?

In simple terms, **Life Insurance** is a way to spread the impact of a financial loss to many people, so the cost to the individual is small. There are a couple of different ways of looking at this:

**A. Assessment**

**Assessment** requires a contribution from each family, individual or group covered by the plan. You could call this "passing the hat" when a family suffers a loss. In the method of assessment, as the group or number of families gets smaller, the amount

each participating group must contribute gets substantially larger. The younger members of the insured group will pay substantially more into the assessment than older ones, and the possibility of a catastrophe that kills many individuals in the group would result in a major hardship for the surviving members of the group.

### B. Prepayment

A better method is known as **Prepayment**. This is the more familiar structure of insurance. The prepayment is also known as the **premium**, which 'buys' a set amount of insurance over a period of time (we'll cover premiums more thoroughly in later units).

This method requires each member to pay a predetermined amount to the fund. This amount the individual or individual family pays is based upon many factors, which will also be covered in detail later. These payments are made according to a fixed time basis. This prepayment method isn't dependent on the size of the group or number of families involved. The insured group, or family is fully aware of how much money they will receive upon the death of an insured member. Simply, the uncertainty of how a loss will affect the surviving members of a family has been removed.

## 2. Life Insurance Concepts

The following is a list of important ideas that illustrate how Life Insurance actually works. Also, there are several defined terms that are important to your understanding of Life insurance.

## A. How Does Life Insurance Work?

The first important idea behind Life insurance is the prediction of how many people, among a much larger group of people, will die every year. While it's impossible to exactly predict when a person will die, through underwriting (assessing) insurance applications, it's possible for the insurance company to determine how many people will die per year. The result is each family, or participating member, may be accountable for their own insurance needs, because each would now pay a specific amount into an insurance fund. These funds are predetermined and paid to an insurance company. The monetary payout upon the death of the insured party is also predetermined and based on the amount the insured party pays into the fund. This exchange of money for coverage makes the costs of insurance known to the individual and the insurance company.

## B. The Insurance Company

When we discuss the fund into which payments are made for coverage, we are talking about an insurance company. Insurance companies collect the prepayments for insurance and then pay out benefits upon the death of an insured party.

An insurance company exists to:

- Sell Life Insurance to those who wish to buy it
- Collect the fixed, prepaid amounts due for the insurance

- Effectively handle the administrative parts of the insurance to include the interests of good business practices
- Pay out the death benefit money to the surviving members of a family that has suffered a loss

Generally, the provider of this insurance is called the insurance company, or **insurer**. The person who is covered by this insurance is known as the **insured**. The person who actually buys the insurance from the insurance company is known as the **policyowner.**

## 3. The Contractual Nature of Life Insurance

Life Insurance is a **contract**. A contract is defined as a legal agreement between **2** or more parties, in which a certain performance is promised, in exchange for a valuable consideration. The parties involved include the ***applicant*** (person making application -- may or may not be the insured), the ***policy owner*** (party controlling all rights under the contract), the ***insured*** (the person being underwritten under the contract) and the ***beneficiary*** (person or entity designated to receive proceeds of the life policy). All parties involved must be competent and of legal age to enter into a legally binding, written contract.

Let's fit these ideas into our discussion of Life insurance. Life insurance is a contract between an insurance company and a policyowner. This contract promises that the insurance company will pay out a monetary death benefit upon the death of the insured person. In exchange, the policyowner promises to pay fixed

payments to the insurance company for this insurance coverage (premiums).

**The Real World . . .**

In Life Insurance the policyowner and the insured can be two different people. For example: Joseph is a 31-year old husband and father. His wife, Rachel, has given birth to their first child. Realizing their new responsibilities to their new family, Joseph and Rachel decide to buy a Life insurance policy. Now that Joseph will be the sole breadwinner, he decides to buy a life insurance policy that covers Rachel, as well as one that covers himself. With the policy that covers only Rachel, Joseph is called the **policyowner**, since he actually bought the insurance and signed the policy. Rachel is the **insured** because it is her life that is covered by the policy.

The physical representation of this contract is the insurance policy itself. Legally, an ***insurance policy*** is the collection of documents, applications, and other papers that spell out the insurance coverage, the premiums, the benefits and other legal aspects of the insurance. Both the insurance company and the policyowner have to sign the insurance policy, making it a legal contract.

**You Should Know . . .**

A Life insurance policy is considered to be a ***unilateral contract***. It's a unilateral contract because only the insurance company is legally obligated to its promises within the life insurance contract. The policyowner, however, can choose to stop making premium payments. The policy would be cancelled, but the insurance company couldn't take any legal action. As long as the policyowner makes premium payments, the insurance company must uphold the promises it makes in the policy.

## 4. What Makes a Contract a Contract?

Now we will discuss the elements of contracts that make them legally binding and enforceable. There are **4** distinct elements to a legal contract:

1) Competent Parties
2) Legal purpose
3) Offer and acceptance
4) Consideration

**Remember . . .**

The elements of a legal contract spell **C.L.O.C.**:

**C**ompetent parties
**L**egal Purpose
**O**ffer and Acceptance
**C**onsideration

That gives you an easy way to remember it for the exam.

Here's a more detailed look at **C.L.O.C**:

### A. Competent parties

This refers to the **2** or more parties who enter into a legal contract. Competent in this context refers to:

- Legal purpose
- Mentally sound
- Without any other impairment of judgment that would affect their entering into a legal contract

**B. Legal purpose**

This refers to the fact that a contract is legally enforceable if it is in pursuit of a legal purpose. For example, a contract to buy and sell illegal narcotics would not be a valid contract.

**C. Offer and acceptance**

This is the agreement between **2** or more parties involved in a contract. One party makes an offer and one party accepts that offer. The policyowner ***makes an offer*** when they complete an application for insurance and submit the first premium payment. The insurance company then ***accepts*** that offer by issuing the insurance policy.

**D. Consideration**

This is the value exchanged for the promises within the contract. The **premium paid** by the policyowner is the **consideration** made in exchange for the coverage within a life insurance policy.

## 5. Other Concepts

Here are some other concepts (hence the above title) that are important to understand regarding contracts:

**A. Contract of Adhesion**

This means that the policy is written by the insurance company and issued to the policyowner. The policyowner does not take part in the construction of this contract. While they may ask for additional coverage or special provisions within the policy, it is the insurance company that actually writes and issues the policy.

**B. Executory Contract**

This means that it is not completed until a future date. The company's promise to pay does not occur until the death of the insured party sometime in the future.

**C. Conditional Contract**

This means the company's promise to pay is conditional on the policyowner's payment of the policy premiums.

**D. Contract of Utmost Good Faith**

This is a contract where the insurance company must rely on the honesty and good intentions of the applicant for insurance when they issue the policy. In turn, the policyowner and the insured must rely on the integrity of the insurance company to fulfill their promises as stated in the insurance policy.

**E. Aleatory Contract**

This means that equal value is not inherent in a life insurance policy. The insurance company may pay out much more money in a death benefit to a policyowner or beneficiary than it receives in premiums paid over the years by that individual.

**F. Personal Contract**

This means that a policy Life Insurance insures a person and not property.

### G. Waiver

This is the giving up or surrendering of a right that is done so with knowledge and consent.

### H. Estoppel

This is related to waiver. It means a person is 'estopped' from using as a defense, the voluntary relinquishment, or waiver, of a known right.

**The Real World . . .**

Before an insurance company will pay out on a Life Insurance policy, they need to receive a proof of claim within a certain amount of time. If the person won't be able to submit the proof of claim in time, the insurance company can waive their right to receive that claim within that particular timeframe. Basically, they extend the person's timeline.

If the company then turns around and refuses to pay the claim because the person didn't get the proof of claim in on time, a judge will issue an estoppel saying that the company has to honor the waiver.

### I. Parol Evidence Rule

This is the presumption that any oral agreements made between the company and the policyowner are included in the written contract.

**Summary . . .**

Let's simplify the basics so far: a Life Insurance policy is a legal contract, where the policyowner makes premium payments to an insurance company in exchange for the promise that the company will

pay out a death benefit to a beneficiary of the insured in the event of the insured's death.

## 6. Mortality

This is one of the basic concepts of Life Insurance. Mortality is how life insurance companies determine who they will insure and how much it will cost to insure people of different age groups.

The **Mortality Table** is a system of predicting beforehand the average number of individuals, of a certain age, who will die annually. Using the specific age, this number is then divided by the total number of people of that age within the population. This gives insurance companies a **mortality rate** for specific age groups for each year.

Below is a basic example of a Mortality Table for a population of **100,000**:

| AGE | NUMBER ALIVE | PER YEAR DEATHS |
|---|---|---|
| 0 | 100,000 | 710 |
| 10 | 98,511 | 121 |
| 20 | 96,652 | 175 |
| 30 | 94,806 | 204 |
| 40 | 92,416 | 328 |
| 50 | 87,625 | 731 |
| 60 | 76,989 | 1,568 |
| 70 | 55,922 | 2,786 |
| 80 | 26,266 | 2,890 |

| | | |
|---|---|---|
| 90 | 4,683 | 1,070 |
| 99 | 62 | 62 |

A Mortality Table shows why insurance premiums are less expensive for younger people than older people. The table shows a drastic jump in the number of average deaths per year when the age bracket of **60** is reached.

Mortality Tables also take into consideration the **Law of Large Numbers**. This mathematical law states that the larger the number, (the total population considered in a Mortality Table) the more reliable and accurate the statistic will be. Thus, the data found within Mortality Tables is derived from the records of millions of people over a long period of time. This factor causes Mortality Tables to be considered very reliable.

# The Need for Insurance

**Objectives . . .**

This section will explain the need for Life Insurance, and why people buy. The information in this Unit will help you provide a valuable service to your customers, as well as deepen your knowledge and appreciation of the benefits of Life Insurance. Covered will be the need for immediate money often experienced by those who have suffered a loss. We will also cover the Accumulation value of a Life Insurance policy. You will be introduced to the Three Income Periods that surviving family members go through after a loss. This is a short Unit, but a an important one.

**Life Insurance** policy proceeds can help ease the financial suffering and hardships a family experiences upon a death. The money paid out from an insurance policy can serve many crucial purposes to the surviving family members. What if the deceased was the sole source of income for the family? The benefits of the policy would allow the surviving members of the family to go on. This is sometimes referred to as *survivor protection, or* ***family protection or simply a family policy.*** A ***family rider*** to a life insurance policy gives the beneficiary or family the choice of taking insurance proceeds in a lump sum or take the coverage over a period of years ot make it last longer for the family.

## NEEDS-BASED APPROACH (Risks and Losses)

One way of looking at the need for Life Insurance is the **Needs-Based Approach**. As you can imagine, the expenses involved with a person's death are sometimes staggering. Estimating these expenses in a **Needs-Based Approach** can help an individual determine how much

Life Insurance to buy. An important factor in this **Needs-Based Approach** is the need for *readily available cash* experienced by surviving family members. These include money for the following types of ***possible losses***:

- Final Expenses
- Mortgage or Rent
- Education
- Debt Repayment
- Emergencies

**Final expenses** are the immediate costs to the surviving family members upon the death of the insured. These can include funeral expenses, hospital bills and any other related expenses that can add up prior to a death (especially in the case of illness or accident).

**A Mortgage or Rent Fund** can allow the surviving family members to pay off a mortgage, or to pay ongoing lease or rent payments. You can see the need for readily available cash with respect to keeping and protecting housing and property after a loss.

**Education Fund** needs and the costs involved with education are on everyone's mind. Computing the cost of present and future education needs is definitely valid in the **Needs-Based Approach** to insurance. Money paid out in a death benefit could be invested to offset future education costs.

**Debt Cancellation** is another important concern. The money paid out from a life insurance policy can be used to pay off credit card balances,

auto loans, and other debt that could potentially cause surviving family members additional hardships after a loss.

**An Emergency Fund** and money to deal with them concern us all. But a family who has just suffered the loss of a loved one especially needs access to large amounts of cash for financial emergencies. This money can give beneficiaries much needed peace of mind after their loss.

## ESTATE AND ACCUMULATION VALUE

A **Life Insurance** policy creates an ***immediate estate*** to solve the aforementioned concerns about money and expenses upon a death. First of all, it pays out it's full value *immediately* upon the death of the insured, a guaranteed amount of money paid out to the beneficiaries of the policy.

There are also the **'Living Benefits'** associated with life insurance policies. It can be a valuable financial resource while the insured is still alive. A **Permanent** life insurance policy (discussed in a later Unit) accumulates a cash value over it's lifespan due to the premiums paid into it.

This cash value can be used as a **Living Benefit** in different ways:

- Withdrawals
- Retirement income
- Loans

**Withdrawals** are available in some policies and allow policyowners to get cash out of their policy as one might from a savings account.

**Dividends** are payments made by the insurance company to certain policyholders. Life insurance policies that pay dividends are called ***participating*** policies. Companies and policies that do not pay dividends are considered ***non-participating***. Any dividend payments are based on the investments the insurance company makes with the money it receives in premiums. This will be fully covered in a later Unit.

**Retirement income** may be accessed by policyowners who reach retirement age. These individuals may then turn the policy into a supplemental source of retirement income payments.

**Loans** can be taken out on the cash value of certain policies. The policyowner borrows the money directly from the insurance company. Additionally, the policy's cash value can be used as collateral by the policyowner to borrow from other lending institutions.

## THE HUMAN LIFE VALUE APPROACH

When dealing with **Life Insurance**, it is important to keep in mind that *no amount of money* could ever even come close to replacing the a human life. This is certainly not the purpose of life insurance. However, when examining the practical and functional view of **Life Insurance**, it is important for the policyowner to consider what economic impact the death of a loved one may result in. Simply put, the *human life value approach* considers an individual's annual income

multiplied by the number of years they will work until they reach retirement age. That **future earning potential** is the individual's **human life value.**

**The Real World . . .**

Charles is considering buying a life insurance policy and is thinking about how much insurance he actually needs. Charles is an accountant and earns $50,000 a year. It will be 20 years until he reaches retirement age. So, Charles multiplies $50,000 (his annual salary) by 20 (years until he can retire) and comes up with $1,000,000. In terms of Life Insurance, Charles may consider his Human Life Value to be $1,000,000 in economic terms. This is a very basic method of determining the amount of life insurance one should buy.

A more comprehensive approach is what is often called **"*Personal Insurance Planning*".** This ***insurance plan*** may be used for anything from the purchase of life insurance only, to the consideration of all income, assets, retirement plans, other investments, and of course, life insurance and annuities, and maximizing growth through an investment plan based on personal ***financial objectives***. This more comprehensive approach is often used by those who are also securities licensed, registered as an Investment Advisor, or hold a Certified Financial Planner (CFP) designation. Sophisticated planning software is available for this method. **Risk Management** techniques including, **Avoidance (reducing risky activities or exposures), Reduction (reducing risk by losing weight or taking blood pressure medicines) , Sharing (distributing premiums and losses among a large group of policyholders) Retention (self-insuring the risk) , and Transfer (buying life insurance to cover**

**the risk).**, are also considered in the protection of property assets as well as future income.

**The Agent World . . .**

What are your legal responsibilities when selling life insurance? Well, the law does not require you to secure complete insurance protection against every conceivable need an insured might have (Jones vs Grewe – 1987). Your primary obligation to clients is to select a company, explain policy options that are widely available at a reasonable cost and secure coverage (Southwest vs Binsfield – 1995). Doing more to help a client determine the amount of life insurance he needs is encouraged by regulators and the industry. However, going further and marketing yourself as an "expert in life insurance needs" escalates your liability. You see, when you establish yourself as an expert, you are no longer just an agent representing an insurance company. You assume the liability that comes with expert status which means a lawsuit and damages if you are wrong in your calculations. Unless you have the skills, be careful how you identify yourself in the real world.

## CAPITAL CONSERVATION VS. CAPITAL LIQUIDATION METHODS

These are two methods used to determine the amount of money required to keep a family or other beneficiary with enough income to remain at the standard of living they were accustomed to before a loss.

**Capital Conservation** uses only the **interest earned** on the principal amount of money to provide income. This allows the **Capital**

**Conservation** method to create an income indefinitely by not depleting the principal amount.

The **Capital Liquidation** method uses ***both*** the **principal and the interest earned** to generate an income through the systematic liquidation of both. This means a smaller principal amount (of life insurance) is required. The **Capital Liquidation** method means the survivors *could* potentially exhaust their source of income.

## THE THREE INCOME PERIODS

There are **3 distinct income periods** a surviving family may experience after the death of a loved one. As you will see, the three income periods change and vary as the situation of the family changes after their loss. The 3 periods are:

- The Dependency period
- The Blackout period
- The Retirement period

**The Dependency period** is the time when the surviving spouse has children (dependents) at home. The family's needs are typically largest at this point.

**The Blackout period** is the period when a surviving spouse no longer has children at home, but is not yet old enough to receive Social Security retirement benefits.

**The Retirement Period** is the period when the surviving spouse is now old enough (age 60) to receive retirement benefits from Social Security.

## *END SECTION*

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

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# Section LO 2

# Types of Life Insurance

**Objectives . . .**

While any life insurer may issue life, disability, term, endowment or annuities, this section will explore the most popular types of life insurance sold today: Permanent Life, Term Life, and Annuities. Permanent life insurance plans provide protection for the lifetime of the insured and accumulate a cash value. In this Unit you will learn the **3 basic types of Permanent Life Insurance are; Whole Life, Universal Life, and Variable Life.** This is an important Unit so take your time and take notes.

While permanent life covers the insured for a lifetime, **Term Life** insurance covers only a specified amount of time. We will discuss different types of Term Insurance. The **face amount** of the policy will be paid only if the insured dies within the term period. The Unit will conclude with a discussion of the Uses of Term Insurance. This is another important Unit, so take notes and go back over the information as need be.

## Permanent Life Insurance

### KEY CONCEPTS

The following is a brief description of several key terms and concepts that are important to **Permanent Life Insurance**. Refer back to them as you need.

**A Permanent life insurance plan** provides insurance protection for the lifetime of the insured, and accumulates cash value for the policyowner.

**Cash value –** A portion of the premiums paid by a policyowner to a life insurance company establish a reserve for future death claims. If the policy is surrendered prior to a death claim, the policyowner is entitled to it's cash surrender value as there is no longer a need for a reserve for a future death claim.

**Endowment** - The ordinary whole life policy assumes a person is statistically dead at age 100. If the face amount or death benefit is $100,000, the policy cash value would be equal to that amount at age 100, and if the insured is still living, **the policy matures, or "endows"** for that amount.

**Insurance protection** - If there's a death benefit of $100,000, and the insured dies at a time when the cash value has accumulated to $33,000, the insurance company adds the remaining $67,000 to pay the benefit. This amount (the benefit minus the cash value) is the amount of insurance protection.

**Modes of Premium Payment**

Life oriented policies offer great flexibility for the payment of premiums. ***Single premium*** policies allows for greater cash accumulation, much like a bank CD. ***Limited pay*** is for those who want whole life protection but do not want to pay the rest of their lives. ***Modified premiums*** allow for smaller premiums in the beginning, higher later. ***Level premiums*** (whole life and term plans) keep payments predictable.. ***Fixed and flexible payments***, like in universal life, allow for the ebb and flow of coverage. ***Initial premium*** plans start at one level with a ***guaranteed maximum premium***. Rates may rise to that level or not.

# PART 1: WHOLE LIFE INSURANCE

A **Whole Life Insurance** policy allows the policyowner to pay premiums for the entire life of the insured, up to age 100. As the premiums are paid over the years, the **Cash Value** of the policy accumulates, as well. When the insured dies, the face value of the policy is paid out to the policy's beneficiary.

A **Limited Pay Life** policy is for policyowners who want **Whole Life** protection but do not want to make premium payments their entire life. For example, policyowners may *not* want to pay premiums after they retire at 65 years old. In this case, the policyowners would pay higher premiums for a shorter period of time, but still have the insurance protection for their entire life.

## 10-PAY LIFE, 20-PAY LIFE POLICIES

This refers to the number of years a **Limited Pay Life** policy requires the payment of premiums; a **20-pay life** means the policyowner pays

premiums for 20 years but has Whole Life protection and the policy is fully paid up after 20 years. The higher premium required for **Limited Pay** policies allows the cash value to build faster than lifetime payments would, and insurance protection provided by the company is less. The advantages to the policyowner are that the policy accumulates cash value faster and the premiums can be paid during peak earning years.

## MODIFIED/GRADED PREMIUM POLICIES

These policies provide a lower premium for an initial period such as three or five years, and then increase to a predetermined level built into the policy. While offering a lower premium,the policies will have a lower cash value as well.

## "BLENDED" (COMBINATION) POLICIES

These policies 'blend' a combination of **Whole Life and Term Life** insurance into one policy. A **Blended** policy can be a good alternative to a policyowner who wants **Permanent** protection but cannot afford the higher premiums needed for a **Whole Life** policy. For example, the **Term** portion may be *70%* and the **Whole** life portion would be *30%* of the total face amount.

Over the years, the **Permanent** policy is expected to generate interest and/or dividends that may be used to increase the percentage of the payment devoted to permanent life. At some point, the **Term** life portion of the premium is expected to be completely replaced with **Permanent** life. The advantage for the policyowner is a *lower* initial premium payment.

## ENDOWMENT POLICIES

**Endowment policies** are a type of **Permanent Life** in which premiums payments are for a limited number of years. If the insured remains living at the end of this premium paying period, the policy **endows**, and the insured receives the face amount of the policy. If the insured dies before the policy matures, the beneficiary would receive the policy proceeds.

The **Tax Reform Act of 1984** changed the rules and determined that any policy that endows before the age of 95 is not considered to be life insurance, and therefore has unfavorable tax consequences. **Endowment Policies** issued before 1984 are not subject to the tax reform act.

## SINGLE PREMIUM WHOLE LIFE POLICY

This policy is purchased with one premium payment, usually a large one. The payment for a **Single Premium** policy might be several thousands of dollars. The *death benefit* is free of income tax, and the inside buildup of cash value was tax-sheltered. **Single Premium** life is now considered to be a *'modified endowment contract'* (see below).

## MODIFIED ENDOWMENT CONTRACT (MEC)

In 1988, the Technical and Miscellaneous Revenue Act **(TAMRA)** defined any life insurance product that is funded more rapidly than 7 years (7-pay) as a **"Modified Endowment Contract."** This certainly applies to single premium life, or any policy requiring less than 7 years of premium payments. Money taken from the policy, in the form of

living benefits (surrenders, withdrawals, loans, etc.) is subject to income taxation. In addition, if the policyowner is younger than 59-1/2 years old, the distributions are considered to be "premature" (similar to IRA's) and subject to a 10% penalty tax.

### JOINT LIFE POLCIES

**Joint Life** polices insure the lives of two or more people: for example, a husband and wife. **First-to-die** joint-life policies pay the benefit to the remaining insured person(s) after the first insured dies and the contract would then terminate. A **Second-to-die Policy** pays the death benefit after both of the insured's have died. These are called **"survivorship policies,"** and often used in estate planning cases.

### ADJUSTABLE LIFE POLICIES

Whole life policies that offer the policyowner some flexibility to change the face amount. If the policyowner decides to increase the face amount, the premiums increase. If the owner begins paying higher premiums, the cash value increases to reflect that change. Because **Whole Life** offers protection for a lifetime, the needs of those insured may change as they proceed through the stages of life. With a **"cost of living' (COLA) rider**, a policy may increase in face amount based on an index such as the Consumer Price Index (CPI).

## OTHER FORMS OF WHOLE LIFE INSURANCE

2 other types of Whole Life insurance:

- Current Assumption Whole Life
- Indeterminate Premium Policies

**Current assumption whole life** is also called "**interest-sensitive"** or **"excess-interest"** whole life. It is structured like whole life in that the contract begins with a fixed premium, a guaranteed minimum rate of return on cash value and a fixed death benefit. However, the original conditions under which these decisions were made are re-visited at regular intervals, say, every five years. At the interval, interest rates and mortality rates may have changed, so the policy is adjusted to reflect the current assumptions about those trends. Certain minimums and maximums are set in the original policy, but within that range, premiums, cash values and death benefits may fluctuate according to the updated information.

**Indeterminate premium policies** start with a low premium rate, usually for about two years. After the initial period, the premiums may be adjusted according to the company's experience with interest rates, mortality rates and expenses. The original policy has a stated ***guaranteed maximum premium rate,*** and the premiums may rise to that level; the premiums may also fall, depending on current conditions.

## PART 2: UNIVERSAL LIFE INSURANCE

**Universal Life Insurance** is a flexible premium, adjustable death benefit, permanent policy that accumulates a cash value. The distinction between **Universal Life** and **Whole Life** is the flexibility of death benefits and premiums. For example, during times of high income, the policyowner may want to increase premium payments, which will lead to higher cash values. The *death benefit* may also be increased or decreased, which will affect the insurance cost and no new policy needs to be written.

Premium payments**,** once sufficient cash value has built up, will become flexible to the policyowner in the future and may be increased or decreased. The cost of insurance is deducted monthly from the **cash value** of the account. As long as there is sufficient cash value in the account the insurance protection continues even if the owner pays no premiums for a period of time. However, if the cash value goes to zero, the owner must put more money into the account to maintain the protection.

**The Real World . . .**

Sheila has held a Universal life policy with a $100,000 death benefit for ten years. The cash value of her account has accumulated to nearly $3,000. She wants to take a year's leave of absence from her job and doesn't feel she can pay the premiums during that time. Once she returns to work, she resumes making regular premium payments.

## EXPENSE LOADING

**Loads** are charges deducted from the premiums paid. These are used to cover sales and administrative expenses. **Front-end loads** are deducted before the money goes into the cash value account. **Back end loads,** more commonly used, assess a charge for withdrawals, surrenders, or policy changes. (An **additional annual load** is made, in most policies, by not paying excess interest on the first $1,000 in the cash value account).

I**nterest earned** on the cash value account earns at the Current rate, which consists of two parts:

- The Guaranteed Rate
- The Excess Rate

The **Guaranteed Rate** is interest that the company agrees to pay for the lifetime of the policy; it is usually around 3-4%. Excess interest may be earned by the insurer depending on the current level of interest rates.

The **Current Rate** is equal to the guaranteed rate **plus** the excess interest that the insurer passes on to the policyowner. The insurers usually tie the current rate to an economic indicator such as the discount rate for certain Treasury bills.

### PARTIAL WITHDRAWALS

**Partial Withdrawals** may also be made from a Universal Life cash value account, subject to a back end load and/or a service fee.

### SURRENDERS

A **Universal Life** contract may be surrendered at any time for its cash value at the request of the policyowner. There may be a **Surrender** charge or, “penalty for early withdrawal”, in the early years of the policy.

## DEATH BENEFITS

**Death Benefits** are also flexible in **Universal Life**. The policyowner may decrease, or increase the amount (with proof of insurability). The cost of insurance will adjust accordingly.

There are two options concerning death benefits: **Option A** provides a **level** death benefit, and **Option B** provides an **increasing** death benefit.

**Note:** With Option A the level death benefit stays level until the cash value approaches the benefit amount. Then there is a "corridor" period where the death benefit increases as the cash value increases.

In order to qualify as life insurance, all Universal Life insurance policies must have an **amount at risk** to meet the definition of life insurance as set forth by the IRS. Otherwise, the policy will lose it's tax favored status and may be subject to income tax.

**Note:** In Option B there is no level benefit; it is always an increasing benefit, the cash value plus the face amount of insurance. From the beginning, as the cash value accumulates, so does the death benefit. Option B requires more premium because the insurance protection, the amount at risk, remains the same.

## PART 3: VARIABLE LIFE and VARIABLE UNIVERSAL LIFE

The distinction between **Variable Life insurance** and other forms of Permanent life insurance is in the cash value and **how it is invested**. The policyowner may choose among stock, bond, and money market investments called 'Separate Accounts'. The rate of return is not guaranteed, it may rise or fall according to the performance of the underlying securities. It is valued daily at the close of the New York Stock Exchange. This is unlike traditional insurance where the general account invests conservatively in mortgages and bonds, and can guarantee a rate of return.

**Note . . .**
Insurance agents selling variable life must be registered with the National Association of Securities Dealers (NASD), passed the NASD Series 6 and 63 license examinations AND filed a variable contracts application with the California Department of Insurance in order to solicit business.

**Variable Whole Life** insurance resembles **Traditional** Whole life insurance in that there is **a fixed premium** schedule. If premiums are not paid on time, or within a *grace period* of 30 days, the policy lapses. There is a guaranteed minimum **death benefit** as long as the premium payments are made.

## POLICY LOANS AND SURRENDERS

With a **Variable Life Policy**, the policyowner may borrow from the cash value, subject to current interest rates for loans. The entire cash value may be taken if the owner surrenders the policy.

## VARIABLE UNIVERSAL LIFE

Rather than a Whole Life 'Chassis', this is a policy that is the same as a regular Universal Life policy **except that it is a securities product with the separate account investment choices described in Variable Whole Life.** Premium payments are flexible and may be made in almost any amount at any time as long as there is enough money to buy the insurance protection. They are also subject to "loads" or charges similar to those in **Universal** life. As in Variable life, the **cash value account** offers various investment options to be directed by the policyowner: stocks, bonds, and money market investments.

Policyowners may allocate among these options as they see fit, though there may be some minimum allocation requirements. A monthly deduction is made from the cash account to pay for the **cost of insurance.** If the cash value is insufficient, the owner is given a grace period to pay a premium to the account.

## INDEXED & GUARANTEED LIFE POLICIES

***Indexed universal life*** is a type of fixed universal life insurance product, which is regulated and distributed in the same manner as fixed universal life. By contrast, indexed life usually provides a downside guarantee of 1% or less, but earns potentially higher upside interest crediting, based on the performance of an outside stock index so a consumer's money is always protected from downturns in the market. However, indexed life also has upside interest crediting potential of 15% or more. ***Guaranteed universal life*** provides a guaranteed level premium and guaranteed death benefits for a limited time . . . just like a term policy. Indexed life and annuity insurance is a moderately conservative interest-sensitive life insurance product suitable for investor savvy individuals. And, be wary of additional charges (transaction fees, riders, etc) that can substantially reduce earnings.

## JUVENILE INSURANCE

**Juvenile Insurance** policies are permanent plans written on those under the age of 15. **Juvenile Insurance** can start an individual's life insurance coverage at an early age in order to have very low premiums. The insured child would also have guaranteed insurance coverage should they become uninsurable later in life. It can also build

a cash value or loan amount that can be used towards the child's higher education. A ***'jumping juvenile'*** policy '*jumps*' when the child reaches the age of **21**. Typically the face amount automatically increases by **5 times** the amount than the original face amount with *no* increase in premium payments. A ***payor rider*** would waive the premiums if the payor (the one paying the premiums) dies or becomes totally disabled.

## INDUSTRIAL LIFE INSURANCE

**Industrial Life** insurance, named for it's use with workers in the factories of the Industrial Revolution, is able to meet the insurance needs of those with limited incomes, who cannot afford high premium payments. The insurance coverage has a face amount for **$1,000** or less. **Industrial insurance** also has a small premium and may be collected weekly or monthly by the agent of the policyowner.

Insurance companies that specialize in **Industrial Insurance** are known as *home service companies*. The small death benefits associated with **Industrial Life** policies usually are for burial expenses, but they may also include provisions for an *accidental death benefit* that would pay out double or triple the face amount, or provide *dismemberment benefits* to the insured for loss of limbs or vision. Industrial policies are usually written as **non-medical** due to the smaller amounts of insurance. The company may also offer other types of policies such as ordinary insurance known as Monthly Debit Ordinary (MDO). These policies have higher face values and premiums. The premiums are paid monthly and can be paid by the policyowner, mailed or automatically withdrawn from a bank account.

# Term Life Insurance

**Term Insurance**, does not accumulate a cash value over the life of the policy, it is death benefit only, or pure protection. Term insurance provides the insured with **peace of mind** that they and they families are protected during the policy period. **Term Insurance** premiums are lower than **Permanent** plans because there is no cash value accumulation to receive if they are still living when the **Term** policy expires.

The basic types of Term insurance include:

a) Level Term
b) Decreasing Term
c) Increasing Term
d) Renewable Term
e) Convertible Term
f) Interim Term

## LEVEL TERM

**Level Term** life insurance death benefits remain constant for the number of years stated in the policy, a period of 5, 10, 15, 20, or even 30 years. Premiums for **Level Term** polices will also be level and may be ***guaranteed level*** for the policy period. After the policy period, the premiums usually increase at a predetermined level. Some policies, however, are ***non-guaranteed level***, which means that after the policy period, the company can increase premiums at its discretion. Still other term policies provide for ***indeterminate premiums*** where a schedule of maximum guaranteed premiums is

determined. The insurer will not charge you more, however, he can vary the premiums throughout the policy.

**Term** polices may have a *re-entry option* that allows the policyowner to pay reduced premiums when they renew and provide evidence of insurability to the insurance company.

## DECREASING TERM

The face amount, or death benefit provided by a **Decreasing Term** insurance policy goes down each year by a predetermined amount and is often used as **mortgage insurance, or mortgage redemption,** because it's amortization is like that of a home mortgage. When the insured dies, the death benefit may reflect the *declining amount remaining on the mortgage*.

## INCREASING TERM

**Increasing Term** insurance is usually combined with a policy as a rider. **Increasing Term** increases the face value and pays upon the death of the insured.

## RENEWABLE TERM

**Renewable Term** insurance allows the insured to renew another term period similar to the one they had before the term expired. They can do so ***without* proof of insurability**. This must be written into the original policy when it is purchased. However, when the policy is renewed, premiums are calculated at the attained age of the insured at the time of renewal. Since the insured is now older, the premium payments are therefore higher with each renewal. Policyowners usually have **30 days** to renew a policy after the previous term expires. The

renewable option *must* be written into the original policy at the time of purchase.

## CONVERTIBLE TERM INSURANCE

**Convertible Term** insurance allows a policyowner to convert, or exchange, a Term policy to **into Permanent** plan. At the time of conversion, the insured has the option of *attained age* (present age) or *original age* (age when policy originated). Since premium payments are based upon the age of the insured, this decision would effect the premium payment should they elect to convert the policy. When original age is used, the premium paid must include back premium to the original issue date. Also, the policyowner may have to make an interest payment that would equal the money the insurance company could have gained on the higher premium payments. In short, by paying the back premiums and interest, the policyowner would build *accumulated value* in the policy at a faster pace.

## INTERIM POLICY

An **Interim Term** policy allows the insured to have immediate protection. The insured does not have to pay for **Permanent** insurance. This insurance covers the **interim**: the time between the beginning of the Term policy and when the Permanent insurance would begin. Usually, insurance companies provide policyowners with temporary Term insurance that will convert to Permanent in *less than 11 months*. Premium payments are based on the insured's age at the time of original application, as would be the premium payment for Permanent insurance when it takes over.

**Term Life** insurance **provides people with the most insurance protection at the lowest available cost**. Although it has no cash value, it fills a need for those who need life insurance protection without the higher premiums involved with Permanent life plans.

**The Agent World . . .**

Most insurance licensing courses spend more pages discussing whole life forms of insurance leading many agent candidates to feel it is the insurance of choice. The authors of this course believe that the wide variety of term policies available today fill a vital role in estate planning, especially during early family growth years where the breadwinner(s) have young, college-bound children and big mortgages. Without large sums of life insurance protection ($500,000 on up), an unplanned death of either breadwinner could spell economic disaster for the surviving family. We have witnessed cases where agents have incorrectly "sold" expensive whole life policies with inadequate death benefits with excessive monthly premiums that sometimes prohibit clients from purchasing other essential coverage such as health insurance. What sense does it make to have provided a small amount of life insurance but ignore the more likely occurrence of a health condition or accident that could cost millions of dollars. Please don't make the same mistake.

## FAMILY PLANS

**Family Plans** provide coverage to each member of a family when the policy is issued. Typically, **Family Plans** provide insurance coverage on a breadwinner, a spouse, and the children in one policy, usually permanent insurance on the breadwinner, and term on the spouse and children. Term insurance is provided, without additional premiums, for all children born or adopted after the policy is issued. This coverage usually expires when the child reaches 18 and is convertible to Permanent insurance.

# Annuities

**Objectives . . .**

An Annuity contract provides an individual a series of periodic payments that last for a lifetime. The owner pays premiums to the insurance company, who then guarantees an income to begin either immediately or at some time in the future. The insurance company determines the amount of the Annuity by considering what return the premiums will earn, when the payee wants the income to start, and his or her life expectancy. This Unit will cover the different kinds of Annuities and their applications.

## TYPES OF ANNUITIES

Annuities are policies issued by an insurer that allow you to save money. Some are used for ***personal or individual annuities for*** saving for retirement or to have a stream of income for a period of years or for life. Annuities are also used in ***business*** to fund 401k plans and other pension benefits. ***Group annuity*** contracts are made between employers and insurers specifically for their eligible employees. Annuities may be classified by ***single or flexible premium, immediate or deferred payout,*** or by the type of cash value account, fixed or variable. Annuities may also be ***qualified***, for use inside retirement plans or ***non-qualified***, used outside retirement plans for personal investing. The structure of an annuity is simple:

- **The Annuitant** is the individual whose life expectancy is used to determine the amount of any life income payment.
- **The Owner** is usually the annuitant but may be another family member or even a business.
- **The Beneficiary** is who will receive the proceeds or income in the event of the death of the annuitant or owner.

**FIXED ANNUITY**

In this type of **Annuity**, payments to the annuitant are fixed over the annuitant's lifetime, or a period specified in the contract. They are based on premiums that are placed in the company's ***general account*** and **earn interest at a fixed rate** of return.

**VARIABLE & EQUITY INDEXED ANNUITY**

These **Annuities** are **invested in securities (mutual funds, stocks, bonds, and/or money markets).** They are kept in a ***separate account*** at the insurance company, apart from the company's general account to keep all dividends, interest, gains and losses separate. The value of the account and payments to the annuitant will vary according to the fluctuating market value of the underlying investments. Agents who sell variable annuities *must* be licensed through the *National Association of Securities Dealers (NASD****). Equity indexed annuities*** are a bit less risky, more like an interest bearing account, where the yield is tied to an equity index like the S&P 500.

**IMMEDIATE ANNUITY**

Income from these **Annuities** begin one payout interval after being purchased. For contracts whose income payments are monthly, the first payout would begin a month after the purchase; if the payment intervals were annual, the first payout would begin in a year. The purchaser must pay for the entire contract at once. This is called a **single premium immediate annuity (SPIA).**

**DEFERRED ANNUITIES**

These Annuities begin income payments after a specified period of time, e.g., when the annuitant reaches 65 years old. They may be

funded with one payment, single premium deferred annuities, or premiums may be paid on a periodic basis over a period of time.

## THE ACCUMULATION PERIOD

The **Accumulation Period** is when the **owner funds the Annuity through premium payments**. It may be a single lump sum payment, or a series of regular premium payments. With a **Fixed Annuity**, a guaranteed minimum rate of interest is paid on the principal; in a **Variable Annuity**, the rate of return varies with the value of the investments funded with the premiums. In both Annuities, **taxes on earnings are deferred until withdrawal begins.**

## ANNUITY PREMIUMS

There are different types of **Annuity Premium Payments**:

- Single Premiums
- Level Premiums
- Flexible Premiums

**Single premium** annuities are funded with one large payment but may be immediate or deferred.

**Level premiums** are a series of equal periodic payments made over time and may be paid at annual, semiannual, quarterly, or monthly Intervals.

**Flexible premiums** are also an option with some contracts. They are paid over a period of time, but the purchaser can vary the amount of the premium between a minimum and maximum amount.

**Accumulation Units** refers to a *variable annuity* only and the purchasing of "accumulation units." This is similar to buying stock in a company; an investor owns so many shares of stock and the total value of the shares goes up or down with the price of the stock. **An accumulation unit is a "share" in the separate investment accounts.** The price of an accumulation unit goes up or down with the market value of the underlying investment portfolio.

Insurance companies use 5 different factors in determining **Premiums** for **Annuities:**

- The **age** at which the payouts begin
- The **gender** of the annuitant
- The **interest rate** the premiums will earn
- The **amount** of the guaranteed payments,
- The **loads** or amounts charged for company expenses

## NONFORFEITURE PROVISIONS

These protect the contract owner if, for any reason, he or she stops making premium payments. The owner does not lose the value accumulated to that point. The account may be surrendered to the owner, or some contracts call for the contract to be considered "paid up," and annuity payments may begin based on the value of the account.

### DEATH BENEFIT

If the annuitant dies during the **Accumulation Period**, before the payouts begin, a death benefit is paid to the beneficiary. This will be at least the total amount of net premiums paid (minus sales and expense

charges). Some contracts will pay the net value of the fund, including the interest earned (minus the expenses).

## THE ANNUITY PERIOD (Distribution Phase)

The **Annuity Period** starts when the payouts begin. Usually, a periodic payment will be paid to the annuitant for the rest of his or her life, or for a specified period of time. According to the type of **Annuity**, payments will be fixed or variable. There are also different provisions in the contracts to account for the death of the annuitant.

A **Fixed Payout** is a payment of the same amount at regular intervals for the rest of the annuitant's life, or for a specified period. The cash value is "annuitized", the life expectancy of the annuitant is considered and reflect paying out the accumulated principle and interest for the expected period of time.

In a **Variable Payout**, the amount of the payments may vary over time. This is because the premiums have been placed in a separate account which invests in market instruments. The value of the account will rise and fall with the market, and the payouts reflect this. Once a variable annuity reaches the payout period, the accumulation units become **annuity units.**

**The Real World . . .**

If the annuitant owns 1,000 **accumulation units** and the cash value has grown to $20,000, the value of each accumulation unit is $20.00. If the first monthly payout is $100, it takes 5 accumulation units (at $20 each) to pay it. For the rest of the contract, the annuitant is paid the value of 5 units each month (now they are called **annuity units**

instead of **accumulation units**). If the underlying investments do well, and within a year, double their value, the 5 units would then be worth twice as much, or $40 each. The monthly payment would be $200. On the other hand, the investments could do poorly and lose half their value. Then the 5 units would be worth $10 each, and the monthly payout would be $50.

## ANNUITY SETTLEMENT OPTIONS

There are several options for **Annuity payments including;**

- Life Annuity (Life Only)-No Refund
- Refund Life Annuity
- Life Annuity Certain
- Joint Life Annuity
- Joint Life and Survivor Annuity

**Life Annuity (Life Only)-No Refund** - The payouts continue to the death of the
annuitant, then stop, regardless of how long the annuitant lives.

**Refund Life Annuity** - With this approach, annuitants are guaranteed to receive at least the account value. If the annuitant dies before the amount is paid out, the beneficiary receives the balance.

**Period Certain** - These contracts guarantee to make payments as long as the annuitant lives, but they also guarantee that, for a certain minimum time period. In the case of annuities, payments will be made whether the annuitant lives or not. If the annuitant dies before the specified period, the payments continue to the beneficiary. If it is a "**20-year Period Certain"** contract, and the annuitant dies after 15 years, the beneficiary receives the payments for the remaining 5

years. However, if the annuitant dies after the 20 years, payments cease.

**Joint Life Annuity** - These are contracts for payouts to two annuitants. After the first one dies, payments cease.

**Joint Life and Survivor Annuities** - These annuities continue payments until the second annuitant dies. After the death of the first annuitant, the payments may decrease, say, to two-thirds: this would be called a *joint and two-thirds annuity.*

**The Agent World . . .**

There are many disputes and lawsuits these days centered on the improper sale of annuities. Seniors, who need liquidity for medical expenses, are incorrectly sold long-term annuity contracts with penalties for early withdrawal. Why are they sold? Longer contracts usually pay better commissions. Don't fall in this trap. If a contract is paying higher commissions, look for the reasons why. If it's too good to be true . . . it probably is!
Who should buy annuities? One rule of thumb follows that a client looking for long-term investment with a tax bracket greater than 15 percent might consider them. Other likely candidates include moderate or high tax bracket individuals looking for a conservative way to shelter current income or growth over a long period of time, i.e. retirement monies. Once an annuity can be established as an appropriate investment, an agent must carefully weigh and discuss options and pitfalls with clients.

## SPECIAL TYPES OF ANNUITIES

**Special Annuities** you should be familiar with:

- Group Annuities

- Tax Sheltered Annuities
- Retirement Income Annuities
- Equity-Indexed Annuities
- Market-Value Adjusted Annuities

**Group Annuities** are sometimes used in employer sponsored retirement plans instead of mutual fund accounts.

**Tax sheltered annuities (TSA)** are available to employees of charitable, educational, or religious organizations. These employees may have funds taken out of their regular paychecks and placed into the **Annuities.** The funds are not taxed as regular income, nor are the earnings taxed while in the annuity. The funds are taxed when they are withdrawn, usually after retirement age, when they may be taxed at a lower rate.

**Equity-Indexed Annuities** are treated as fixed annuities in that it is not considered a registered securities product though the interest rate credited is linked to an equity index, such as the *Standard and Poor's 100*. There may be a guaranteed minimum interest rate, and principal may be guaranteed as long as the annuity is held to term. If the index goes up, so does the return on the **Annuity.** If the index goes down, the **Annuity** may provide a minimum rate of return as well as a maximum based on the “participation rate”, any interest rate cap in the contract, and a margin or administrative fee. A complex product, the equity indexed annuity can be subject to surrender charges and may even lose money.

**Market Value Adjusted Annuities** are fixed annuities as well. The adjustment will apply only if the contract is surrendered early and most often acts as a penalty. A change in interest rates however, a decrease, could actually add to the value.

**IRA or Roth IRA accounts** may also be funded with annuities just as well as mutual funds or certificates of deposit.

## Suitability in the Sale of Life Insurance and Annuities

Suitability is the appropriateness of an insurance product for the purchaser's financial situation, risk tolerance, and goals. A producer must understand the client's personal finances before helping select financial products. Determining a products' suitability is a requirement of the agent, **especially in regard to Seniors**.

In order to ensure the right products you need to discuss the following before making a recommendation;

- Age
- Occupational status
- Marital status
- Dependents status (number and types of dependents)
- Annual income and sources
- Life expectancy
- Family health
- Beneficiaries
- Consumer's existing insurance and /or annuities
- Consumer's insurance needs and objectives

- Ability to pay
- Risk tolerance
- Investment experience
- Assets and liabilities
- Savings and investments
- Liquid net worth
- Source of funds
- Time frame or investment horizon
- Asset allocation or present diversification
- Concern for preservation of principal
- Tax status
- Tax advantages if needed
- Retirement goals and considerations
- Surrender schedules or withdrawal penalties

Determining the consumer's awareness of ***liquidity limits and surrender charges*** associated with annuities is essential. There should also be ***standards for determining whether an agent's recommended transactions*** meet the consumer's needs and financial objectives through a schedule annual review. **Failure to disclose** any tax consequences of annuity transactions, unexpected surrender charges, loss of death benefits and other types of consequences when selling a deferred annuity **may be unlawful.**

**A Word About Selling Annuities to Seniors**

In California, marketing life, annuities, or disability to seniors who are **65** years or older, have specific regulations. Policies have to include a **30**-day free look period, a written comparison of any existing health coverage, and the person has to receive advice concerning HICAP's free services to seniors (the Health Insurance Counseling and Advocacy Program). ***Seniors are particularly vulnerable*** because they may be at an age where do not comprehend, hear well, see clearly or they are just plain gullible. A special code of ethics should be exercised when selling products to seniors.

**Special Disclosure For Seniors Buying Variable Annuities**

Seniors buying a variable annuity need to know and it must be disclosed in the variable annuity contract that if the senior wants his ***funds immediately invested*** in the annuity, but cancels within the allowed 30 days, he is only entitled to a ***refund of the annuity account value.*** That means ***he could get back less than the amount he invested*** based on the market doing better or worse than the date he entered. Returning the policy after 30 days can also trigger a surrender charge. Variable annuities are not a typical investment for seniors!

***These disclosures should be present in every policy on the cover page or policy jacket in 12-point bold print with 1 inch of spacing on all sides or printed on a sticker that is affixed to the policy.***

## *END SECTION*

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes A red flashing button will warn you.**

# Section LO 3

# All About Life Insurance Policies

**Objectives . . .**

This section is will explore the inner workings of life insurance policies, including policy provisions, riders, premiums, dividends, settlement options and loans. Take your time with this section, it contains a lot of complex but important information you need to know for the exam and your career.

## Common Policy Provisions

### ENTIRE CONTRACT CLAUSE

Simply stated, a ***life insurance policy defined*** is a contract between the insurance company and the insured or the policyowner. To prevent any misunderstandings concerning what the policy provides, **the application, the policy itself and any attachments** are considered to be the **entire contract**. Any sales information, or verbal agreements not attached, have no bearing on the policy.

Any riders, exclusions or amendments to a policy *must* be attached, in writing, and approved by company. It is important to note that agents *cannot* make any changes to a policy. Designated officers of the insurance company must approve any changes.

**The Policy Title (Specifications) Page … No Standard Policy**

Unlike fire and casualty contracts, there are NO STANDARD LIFE POLICIES. However, information that typically appears on the policy title ***(specification) page***, includes: the insured's name, the insurer's name, the policy number, date of issue, type of policy (whole life, term, etc) , right to examine (10 to 30 days), the face amount of insurance, the ***premium mode (annual, quarterly, monthly)*** and more.

**A Note on Policy Delivery…**

When an agent and a customer complete an application for insurance, the customer pays the first full premium and receives a ***conditional receipt*** (in fire and casualty policies, the receipt would be a ***binding receipt*** that actually "binds" the policy . . . with life insurance, approval is conditional on the insured's health, application, etc). In essence, the insured has a ***temporary insurance agreement*** for a ***temporary term*** (for a specified period of time, or until the insured is approved). Once underwriting has approved the application the insurance company will issue a policy. The means of delivery in California must be by:

- Registered or certified mail
- Personal delivery with a signed receipt
- First class mail with a signed receipt

The burden of proving delivery is on the insurer. But, if the insured has paid premiums pursuant to the contract, a policy is deemed to have been received six months after date of issuance.

**INSURING CLAUSE**

This is the basic statement of the policy that states the insurance company will pay the **specified face amount of the policy**, that is,

the maximum **limit of liability**, upon the death of the insured, to the beneficiary stated in the policy.

**EXECUTION CLAUSE**

This clause states that the contract of insurance stated within the policy will be **executed** (carried out) when the insurance company and the insured both meet the conditions of the contract.

***Incontestability and Suicide Clauses*** – after 2 years have passed with a policy in force, the life insurer no longer has the right to contest the policy for any misstatements the insured may have made in his application. Suicides that occur within 2 years (may vary) may be contested, thereafter, the policy is incontestable.

**CONSIDERATION CLAUSE**

The consideration is the **premium** paid by the insured to the insurance company in exchange for the insurance coverage within the policy.

**CONVERSION PRIVILEGE**

A clause in a life insurance contract that makes it easier for individuals to convert a term policy to a whole life policy

**FREE LOOK CLAUSE / RIGHT TO CANCEL**

Once a policyholder receives and reviews a policy, he has the ability to return (cancel) ***in no less than10 days and no more than 30 days of policy delivery***. He is entitled to a full refund of all premiums paid. The policy would pay the beneficiary if the insured dies during this period if the initial premium was paid.

**Senior Free Look. . .**

This Provision must allow the customer a Free Look or ***right to cancel*** period of ***at least*** 30 days if it's a Senior, age 60 and over.

**Surrender Charges** – Be aware of an advise your clients that many life policies have very costly surrender charges and /or periods when it is not feasible to surrender the contract. If a policyowner wishes to cancel outside of the free look period, surrender charges could reduce cash values or completely eliminate them. Example: Paul purchased a universal with high annual premiums. Paul continued to receive statements showing a cash value of $55,000. Upon further inspection, however, the surrender value for the first 5 years was $0, i.e., if Paul cancelled the policy during the first 5 years he would receive NO cash value despite his payment of expensive premiums.

## OTHER OWNER'S RIGHTS

The **policyowner** (who may or may not be the insured) has certain rights pertaining to the policy that is owned. First, the policyowner has the **right to name (select) the beneficiary**. The policyowner can also determine **how money can be paid out (change payment mode)** , including in a lump sum or as a monthly income stream. They also have the right **to assign the policy**, which means the policyowner could borrow funds from a bank and assign the policy to the bank as collateral for a loan. Right to access ***cash value***. When the loan has been fully repaid, the policy would then be reassigned to the **policyowner**. There can also be an absolute assignment of a policy. This usually is when the policy is given as a gift, and ownership is transferred permanently. A policy may also be assigned to a creditor, who has the right to take whatever amount is owed should the insured die before the debt is repaid.

A **policyowner** may use a life insurance policy that has accumulated a ***cash value*** to obtain a loan. A **policyowner** can also decide how the premiums for the policy should be paid: annually, semi-annually, quarterly or monthly. They also have the right to change this premium payment schedule. A **policyowner** also has the right to decide ***how to use any dividends*** paid out by the insurance company.

**Policy changes** – Policyowners have many options during the course of owning their life policies, such as changing the ***payment mode*** from annual to monthly, changing or determining ***eligible beneficiaries***, name ***primary and contingent beneficiaries***, ***converting the policy*** from term to whole life, ***loans against cash value***, ***using dividends*** (if any) form the policy to pay premiums, etc.

## BENEFICIARY CLAUSE

A beneficiary is the person named to receive payment of the proceeds of a life insurance policy when the insured dies. There can be many ***eligible beneficiaries*** . . . a **primary beneficiary**, the person or persons named as first beneficiary, and/or a **contingent** or second beneficiary. A contingent beneficiary will only receive the proceeds if they survive the **primary beneficiary.**

***Rights of Beneficiaries and Creditors –*** A policyowner who fails to name a beneficiary or designates his estate as his life insurance beneficiary will subject all proceeds from the policy to creditors chasing his estate. Using a named beneficiary, like a spouse, may avoid creditors of the policyholder but subject the proceeds to claims of your spouse's current and future creditors. Naming an irrevocable trust, that holds proceeds for the benefit of a named beneficiary, will do more to shield proceeds from creditors.

***Per capita*** (latin for "by the head") means that the proceeds are paid to any named beneficiaries still living. A named beneficiary who is

deceased at the death of the insured will not be included in any payment of proceeds.

***Per stirpes*** (latin for "by the root") is a beneficiary designation specified to **pass a deceased beneficiary's share to their heirs**. *An example* would be a policyowner designating both a son and daughter as primary beneficiary in equal shares. If the son was deceased at the time of claim, the proceeds would be paid to the daughter under the normal "per capita designation". With a "per stirpes" designation, the deceased son's share would pass to his children.

## REVOCABLE VS. IRREVOCABLE BENEFICIARIES

A **revocable beneficiary,** the most common designation, is one that is named in the policy, but **can be changed by the policyowner.** An **irrevocable beneficiary** can not be changed by the policyowner without permission from the **irrevocable beneficiary,** nor can any changes to the policy be made, or use the cash value of the policy to obtain a loan. When an **irrevocable beneficiary** has been named, a change can be made only if the **irrevocable beneficiary** consents in writing to it.

## MINORS AS BENEFICIARIES

**Minors** cannot receive or control the proceeds of a policy. If a **minor** is named as a beneficiary and the insured dies before the **minor** reaches legal age, custody and guardianship questions may arise and the outcome determined in a courtroom after someone is

appointed by the court to handle the money for the **minor.** The result may not be what the insured intended, especially with step-families when a spouse or children may be unintentionally excluded.
The issue of guardianship may be addressed in a will, but establishment of a **trust** may be in the best interests of all parties.

## ESTATES AND TRUSTS AS BENEFICIARIES

A policyowner can also name their **estate** as the beneficiary of their policy, **a business**, **a trust, or a group of stockholders of a corporation**. However, there are many legal complications in these situations. A **life insurance trust** may be created in order to invest, manage and pay out the money associated with a life insurance policy. These **trusts** may be created **inter vivos**, while the insured is alive, and the trust owns the policy, or a trust can be **testamentary**, funded when the insured dies, with the money being placed into the **trust.**

## UNIFORM SIMULTANEOUS DEATH ACT

Problems can arise when both the insured and the primary beneficiary are killed in the same accident. If determined that the insured outlived the primary beneficiary, then the money from the policy would be paid to the contingent beneficiaries. If the primary beneficiary outlives the insured, than the money would be paid into the primary beneficiary's estate. However, it is often impossible to determine if one person outlived another. The **Uniform Simultaneous Death Act** was established to deal with this type of problem. This law states that if it is not possible to determine who died first, **it is presumed the primary beneficiary died first and the policy would pay to the**

**contingent beneficiary.** If no contingent beneficiaries were named, then the money would be paid to the insured's estate.

## COMMON DISASTER CLAUSE

A **common disaster clause** states that a beneficiary must be living after a specified length of time following the death of the insured. This provision is used in when the death of the *insured* and the *primary beneficiary* occur at or near the same time. The *beneficiary* must outlive the *insured* by 10, 15 or 30 days: whichever is specified by the policyowner. The **Common Disaster clause** ensures that the *contingent beneficiary* receives the policy's benefit pay out if both the *insured* and the *primary beneficiary* die within this period of time.

## INCONTESTABLE CLAUSE

This clause simply states that a life insurance policy that has been in effect for a certain length of time, usually two years, it can **no longer be voided or contested** by the insurance company. Only the non-payment of premiums would terminate a policy at this point. If death occurs during that period, if the insurance company discovers reason to void a policy, it may do so.

## MISSTATEMENT OF AGE OR GENDER CLAUSE

Since the insured's age is an important factor in determining the correct premium for coverage they receive, the **misstatement of age** clause protects both companies and policyholders from an error in recording their age or gender in a policy. If discovered while the insured is living, the company can correct and request or refund the difference in premiums, or adjust the face amount of insurance.

If the insured is deceased, the company will adjust the amount of proceeds payable to that amount of insurance which the premiums paid would have purchased based on the correct age or gender.

**Misstatement of age** is usually unintentional and historically resulted from the inaccurate recording of births. It may also be a result from taking the application, or even a processing or keyboard error in producing the actual policy.

## SUICIDE CLAUSE

A **Suicide Clause** states that if the insured commits suicide within a certain period of time, usually two years, the policy is voided and the premiums refunded. **After this period of time, however, suicide is covered.** This clause prevents anyone who is planning suicide from benefiting from a life insurance policy.

## GRACE PERIOD

If the insured fails to make a premium payment, the insurance company will not immediately cancel the policy but instead, give the policyholder 30 days to pay the premium, during which time the policy is still in effect.

## REINSTATEMENT CLAUSE

After expiration of the grace period, a policy will lapse due to non-payment of premiums. When this occurs, companies will **reinstate** a policy if the following conditions are met:

- The policy has been lapsed for less than three years
- The policyowner must pay all back due premiums plus interest

- The insured must be able to show proof of insurability

It is normally to the policyowners advantage to reinstate a policy if possible as it may have lower premiums or other benefits not available in a new policy.

# OTHER CLAUSES

## SPENDTHRIFT CLAUSE

A person who spends money wildly or with little regard is known as a spendthrift. A **spendthrift clause** allows the policyowner to protect the money by preventing the beneficiary from:

- Transferring the money
- Borrowing money on the financial strength of the policy proceeds
- Taking a lump sum payment

The money would be paid to the beneficiary in some other way than lump sum and would be protected from the beneficiary's creditors while still held by the insurance company.

## PRIVILEGE OF CHANGE CLAUSE

This clause states the conditions where a company will allow the insured **to make a change** in their policy. A **change** that requires a higher premium payment will most likely be approved. But if the **change** would lead to a lower premium payment (thus exposing the insurance company to more risk), proof of insurability or a physical exam *may* be necessary.

## AUTOMATIC PREMIUM LOAN CLAUSE

This clause allows the insurance company to use a portion of a policy's cash value, when needed, to pay premiums to prevent a policy from lapsing. **Automatic Premium Loan** pertains only to permanent, cash-accumulating life insurance policies. This must be requested in a policy. Interest is *always* charged on the loan, and the outstanding loan amount subtracted from the death benefit should the insured die.

## POLICY REPLACEMENT

**Policy Replacement** is defined as a new life insurance policy or annuity is purchased and a current in-force policy or annuity is going to be:

- Lapsed, surrendered, partially surrendered, forfeited, or otherwise terminated
- Changed to lower the policy's term or benefits
- Reissued with a reduced policy cash value
- Converted to a nonforfeiture benefit
- Used in a purchase with money withdrawn, borrowed or obtained from the surrender of an existing policy

**The Agent World . . .**

Be very careful when you are replacing a client's existing policy with one of fewer benefits. In Higginbotham vs Greer, an agent replaced a client's "A-Rated Company Policy" with a lesser rated company. Financial problems with the insurer landed in the agent's lap!

Also consider that a new replacement policy may be bad for a client because of new suicide/contestability limitations, higher premiums

down the road based on age, new expenses, new surrender charges and loss of privileges and options under the old policy.

There are also instances where an agent advised a client to cancel an existing policy before the replacement policy kicked in. Sure enough, when there is no coverage in force claims will occur . . . and, the agent will likely be held responsible for the gap in coverage losses.

Any insurance company that is replacing the policy of another must notify the existing insurance company of the **Policy Replacement** within 3 working days of receiving the new application for insurance. The new insurance company must also keep the notice of replacement for at least **3** years.

Here are some exemptions when policy replacement doesn't apply:

- Credit Life Insurance
- Group Life Insurance or annuities
- When the existing policy is being replaced by the same insurance company
- A policy that is a contractual change or conversion

**Policy Replacement** regulations are in place to ensure that insurance consumers are protected during transactions that involve the Replacement of a life insurance policy or annuity. Policy Replacement refers to any transaction involving a policy being lapsed, surrendered, or converted.

The purpose of the regulations involving Policy Replacement is meant to regulate the activities of insurance companies and their representatives. These regulations also protect the interests of

insurance consumers by establishing codes of conduct and assure that an insurance consumer receives timely and accurate information so they can make a good decision about the insurance they buy.

Policy Replacement regulations also reduce any misrepresentation or incomplete disclosure. Finally, these regulations establish the penalties for failure to comply.

Every agent who accepts an application for life insurance or annuity, shall submit to the insurer both of the following:

- A statement signed by the applicant as to whether replacement of existing life insurance or annuity is involved in the transaction.
- A signed statement as to whether or not the agent knows replacement is or may be involved in the transaction.

Where a replacement is involved, the agent has to do all of the following:

- Present to the applicant at the time of application, a "Notice Regarding Replacement of Life Insurance" signed by both the applicant and the agent and left with the applicant.
- Obtain a list of all existing life insurance or annuities to be replaced, identified by name of insurer, the insured and contract number.
- Leave with the applicant the original or a copy of all printed communications used for presentation to the applicant.
- Submit to the replacing insurer with the application a copy of the replacement notice.

- Every agent who uses written or printed communications in conservation shall leave with the applicant the originals of any materials used.

**Policy Replacement Disclosure .& Penalties . .**

Each agent or broker shall present to an applicant the following notice:

Notice Regarding Replacement: Replacing your Life Insurance Policy or Annuity? Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one--or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits. Make sure you understand the facts.

You should ask the company or agent that sold you your existing policy to give you information about it. Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest. We are required by law to notify your existing company that you may be replacing their policy.

**Penalties**

Agents who do not comply with replacement procedures can be fined an administrative penalty of no less than $1,000 for the first violation, $5,000 to $50,000 for a second offense. Insurers violating these replacement rules as a general business practice can incur penalties between $30,000 to $300,000 for each violation.

**POLICY EXCLUSIONS**

Life insurance polices may contain **Exclusions**–things or occurrences for which it will not pay out. The following is a list of the most common exclusions that may be found in life insurance polices:

- **Hazardous Occupation or Hobby Exclusion** – This exclusion will not allow a policy to pay out should the insured die as a result of a dangerous occupation or hobby
- **War and Military Service Exclusion** – Payment will not be made if the insured dies while a member of the armed services or dies as the result of an act of a declared war
- **Aviation Exclusion** – This exclusion prevents a policy from paying out should the insured die from aviation activities, except as a passenger on a commercial flight or a member of a commercial flight's crew.

# Policy Riders

**Objectives . . .**

This section will cover the importance of Life Insurance policy Riders. These specific provisions to the policy are attached to it, or 'ride it'. Riders are important elements to policies and include options for additional coverages.

## WAIVER OF PREMIUM

One of the most common Riders found in Life Insurance policies, the Waiver of Premium rider allows the insured, when totally and permanently disabled, to be excused from paying the premiums due on their policy. Coverage does not lapse despite this non-payment of premiums as they are “waived” by the company. This rider must be requested and added to the policy for an additional premium. It is important to note that the insured's disability must be considered total and permanent and prevent the insured from earning a living in their usual or any occupation. There is a waiting period from the time of

disability until benefits begin, usually 6 months. If and/or when the insured recovers from the disability, they resume paying the policy's normal premiums. Most companies will not allow a customer to add a Waiver of Premium rider to a policy once they reach age 60 or 65, and the rider expires due to the insured reaching age 60 or 65. The premium would then be reduced by the cost of the rider.

In a flexible premium universal life policy, **Waiver of monthly Deduction**, provides that the monthly mortality charges are waived.

There are 3 exclusions that are typically found in a Waiver of Premium rider concerning the disability:

- Injuries sustained while committing a crime
- A self-inflicted injury
- Injuries sustained while in the military during a time of war

## DISABILITY INCOME RIDER

A Disability Income Rider provides the insured with a regular monthly income while permanently or totally disabled. The dollar amount of this guaranteed income is typically a percentage of the face value of the policy. The insurance company would pay a certain amount of dollars for every $1000 worth of coverage. This rider also lasts for the length of the disability and also includes a waiting period before payment takes effect. The Disability Income Rider can be paired with the Waiver of Premium Rider. Or, one may be attached without the other.

## ACCIDENTAL DEATH BENEFIT RIDER

An Accidental Death Benefit Rider pays an additional amount if the insured should die as the result of an accident. It is generally double the face value amount of the policy and referred to as “double indemnity”. This rider must be specifically requested by the insured and would result in an added premium. There are 5 exclusions that are not covered by most Accidental Death riders:

- Death in war
- Death while committing a crime
- Death from engaged in aviation activities not associated with commercial airlines
- A self-inflicted injury resulting in death
- Death as a result of a riot or insurrection

## ACCIDENTAL DEATH AND DISMEMBERMENT

This rider will pay additional benefits should the insured be dismembered. The AD&D rider will also pay a total death benefit in cases of the loss of sight in both eyes or two limbs. These AD&D rider benefits are sometimes included in with an Accidental Death Rider.

## PAYOR RIDER

The Payor Rider concerns Life Insurance policies in which the insured is a minor but the policyowner–the individual paying the premiums– is a parent or legal guardian. If the parent or legal guardian should die before the minor reaches legal age, then the insurance company would waive all premiums due for the policy until the minor reaches legal age. The coverage would remain in full force during this time. The specified age in the Payor Rider is usually 21 or 25. This is due to the

fact that few 18-year-olds (the usual legal age) have the means to pay life insurance premiums. The Payor Rider is an additional premium.

## GUARANTEED INSURABILITY RIDER

The Guaranteed Insurability Rider provides that the insured can purchase more life insurance at specified times without proof of insurability. It may be added to juvenile policies and is not available over the age of 40. When the insured reaches a certain age such as 25, 28, 31, 34, 37, or 40 where the option to purchase an additional amount of life insurance is available, they have 90 days to do so. The insured may also elect to purchase insurance at alternate optional dates such as marriage, or birth or adoption of a child.

## ACCELERATED BENEFITS RIDER

This rider is sometimes known as the 'living benefits rider'. An Accelerated Benefits Rider allows a policyowner who becomes terminally ill, or may require long-term care in a nursing home to **receive an advance on the death benefit while still living**. If he qualifies, ***the insured may take the accelerated death benefits in a lump sum or opt for periodic payments***. This benefit helps to ease some of the massive bills and expenses the insured is likely to incur while in this situation.

**Selling Accelerated Benefits?**

If policies you sell involve accelerated benefits you need to understand the following:

- Accelerated benefits may not be as good as a stand alone long term care policy.
- Accelerated benefits riders may be triggered by simply events whereas long term care benefits may involve the loss of activities of daily living before triggered.
- Is there an elimination period before coverage kicks in? If so, you must be sure to describe it.
- Benefits under an accelerated rider or long term care policy may never be used.
- Exactly what benefits, services and duration of coverage are provided is benefits ARE needed.
- Restrictions on benefits . . . maximum 50% withdrawal, cap on daily services amount, coverage for a limited time, etc.
- Tax deductions for premiums or the taxation of lump sum benefits.
- Income and death considerations . . . is the coverage adequate?

Without an Accelerated Benefits Rider, a terminally ill insured may choose to sell their life insurance policy to a **Life Settlement** company. The policy is **"sold" at a discounted value** which may be from 50 to 80 percent of the actual death benefit. With an **Absolute Assignment,** the life (viatical) settlement company becomes the new owner, premium payor, and beneficiary.

**Stranger Oriented Life Insurance (STOLI)** refers to a recent trend whereby older individuals (65 to 85 years of age), who are not facing current health concerns, buy life insurance policies with the specific intention to sell them to a third party***(life settlement***), immediately or in the future. The buyer pays a discount and becomes the new owner of the policy, paying all premiums and collecting death benefits when the insured dies. Be careful of ***fraudulent*** activities in this area where agents induce seniors to buy and sell these policies.

**LEVEL TERM RIDER**

A Level Term Rider may be used when an additional amount of coverage is desired for a certain period of time. In this case, the base policy would be a permanent policy and the rider would be the Level Term Rider. Many parents elect to purchase this rider until their children get out on their own. The rider must also be equal to or greater than the premium paying period of the whole life policy. It would not be permissible to attach a 15-year term rider to a life insurance policy with only 10 premium payments due over the life of the policy. The ratio of coverage between a Level Term Rider and a whole life policy is typically 3 to 1 or 5 to 1. It is important to note that the insured cannot cancel the whole life policy and keep the Level Term Rider in force. However, the Level Term Rider can be cancelled without affecting the whole life policy.

## DECREASING TERM RIDER

A Decreasing Term Rider is also combined with a permanent policy. This rider is usually written in 10, 15, 20, 25 or 30 year periods. It also has a coverage ratio of 3 to 1 or 5 to 1. The face amount of a Decreasing Term Rider decrease every year the coverage is in force. This causes a Decreasing Term Rider to have a lower premium payment than a Level Term Rider. Many insurance companies also provide Increasing Term Riders. This rider guarantees that the cash value, as well as a dollar amount nearly equal to the amount of premiums paid over the term, will be paid to the policy's beneficiary upon the insured's death. Therefore, the premiums for this type of policy would increase each year in accordance with the increase of the benefits.

## COST OF LIVING RIDER

A Cost of Living Rider allows the insured to automatically purchase additional life insurance without evidence of insurability. This amount of increase reflects rising inflation and is based on the consumer price index (CPI). There is a premium charge for adding this rider to a policy, and the additional purchases will result in an increase in the total premium.

## RETURN OF PREMIUM RIDER

This rider is often an effective sales incentive to a potential customer. But it also can be a valuable provision to a policy. A Return of Premium Rider states that should the insured live to specified age, a dollar amount equal to the amount of premiums paid over the term of the policy would be paid back to the insured. A Return of Premium Rider would result in a higher premium payment.

## LIVING NEEDS (Living benefits, terminal illness and critical illness

Living Need- This rider allows a terminally ill person to obtain part of the insurance proceeds prior to death. The purpose of this benefit is to provide for the nursing, in-home care and other medical expenses. Most companies advance 40% of the policy proceeds.

## LONG TERM CARE RIDER

This rider is similar to the living need rider. It differs because the insured does not have to be terminally ill to receive proceeds from the policy. Usually this rider is sold as health coverage. Most companies will allow you to borrow up to 80% of the policy's death benefit. Terminal illness may be allowed up to 95% of the death benefit.

**Long Term Care** Insurance (LTC) is becoming perhaps the most important type of health insurance in the U.S. With our aging population growing rapidly, the funding of programs and policies to provide LTC is getting a lot of attention.

Generally, when discussing **LTC**, we mean long-term nursing home care. The number of **LTC** polices has increased, and will continue to do so. These polices are still evolving in respect to what benefits they provide, the lengths and costs of the policy, and are adjusted as insurance companies and the government realize the future ramifications of **LTC**.

The National Association of Insurance Commissioners has developed a model that most states use, to address the key issues whether one is evaluating a long term care benefits as a rider or stand-alone policy:

- A benefit period of at least one year
- A free-look period
- Prohibitions of exclusions against Alzheimer's patients
- Standards for preexisting conditions
- Strict restrictions on cancellation, cancellation due to aging, guaranteed renewability

Economic issues have made consumers more aware of the importance of this type of policy. Medicare and Social Security do not cover **LTC**.

## ANNUITY RIDERS

Insurers have created a number of riders that, for a fee, can be attached to the basic annuity to guarantee a minimum return of principal or earnings, guarantee a minimum income to heirs, offer long-term care benefits and more. Most of these add-ons add to the cost of the annuity or reduce the overall return.

### NO LAPSE GUARANTEE RIDERS

The most dangerous aspect of life insurance is the risk of the policy potentially lapsing. The no-lapse guaranteed benefit rider (typically associated with a universal life policy) imposes a premium payment schedule. This requires minimum payments be made on a regular schedule and avoids the policy from lapsing on a policyholder, unknowingly.

# Premiums

**Objectives . . .**

Understanding Premiums and how they are determined, will be very important to your success with the licensing exam as well as your career. In this Unit we will define Premiums, look at how insurance companies determine Premium payments, how Premiums can be paid, and other concepts involved with Life Insurance Premiums.

**Premiums** are the money an individual pays to an insurance company for Life Insurance coverage. The **Premium** is the consideration given, that is, the cost of the policy to the insured. Investing **Premiums** are how insurance companies make a profit. There is a balance when it comes to figuring what a premium should be. If it is too low, then an insurance company will not be able to cover it's costs and go out of business. But the premiums cannot be too high, or the insurance company will not be competitive with other insurance companies.

**The Agent World . . .**

Premiums for life insurance are almost always made payable to the life insurance company. Agents must forward these monies within 7 days. In Evanston vs. Ticker, an unsuspecting agent was told to have his clients make their premiums payable to an intermediary (bad agent) who proceeded to cash the checks. He also failed to secure proper coverage and refused to pay the money back. The new agent was liable for $75,000 in "lost premiums".

## PREMIUM PAYMENTS

A typical life insurance policy will be paid:

- **Annually** – once a year
- **Semiannually** – twice a year
- **Quarterly** – four times a year
- **Monthly** – once a month

The method of payment chosen by the insured determines how far in advance from the time the policy is approved that they will be covered. For example, if this first **Premium** payment is an annual one, then the insured is covered for that entire upcoming year. Life Insurance policies are actually paid in advance this way. It is important to note that life insurance companies compute *all* **Premium** payments on an annual basis. They prefer annual **Premium** payments because it allows them to earn more interest on more money throughout the next year. Plus, annual **Premium** payments result in lower operating expenses. After all, receiving one payment a year (*annually*) is more cost effective than receiving 12 payments a year (*monthly*). Therefore, any method of payment other than annually will result in a *highe*r total payment.

The company will figure the amount of interest lost and the added operational costs. They would then add in the dollar amount of this lost revenue to the premium payment to recover them.

**The Real World . . .**

This is a fairly simple principle, but it is still an important one. Samantha pays her Life Insurance premium once a year. Megan and her husband Alex pay their Life Insurance premiums monthly. Samantha would have a *lower* total premium payment for that year than Megan and Alex. The insurance company had to add a cost for the lost interest on Megan and Alex's Premium payment since they do not pay *annually.*

**More premium modes . . .**
There are many more "modes" of paying life insurance. Consider the following, many "flavors" of life policies you may encounter:

Single Premium Life --

## HOW PREMIUMS ARE CALCULATED

**Mortality** is the biggest element of how insurance companies calculate their **Premiums**. The ability to accurately predict how many people of a certain age will die in one year is crucial. This allows the insurance companies to figure how long those they insure will live, when they will have to pay out benefits to the insured, and how much revenue they can expect to earn on **Premiums** in respect to a person's life span. Being a business, insurance companies have **operating expenses** such as *payroll, taxes*, *building rent and maintenance*, etc. Obviously, these expenses are figured into the calculations of premiums, as are

the earnings or **rate of investment return** insurance companies are able to generate by investing Premiums. These factors could possibly raise or lower premium costs for a given time period, depending on how well the insurance company is doing.
In addition to Mortality, Operating Expenses, and Earnings, there are other factors that determine an individual premium including:

- Age
- Gender
- Overall health condition
- Lifestyle habits
- Occupation

## INSURANCE COMPANY RESERVES

It is important to note that the **Insurance Commissioners** of each state require every company to have a certain amount of money on **reserve**– an amount large enough to fulfill the promises of paying out future death claims. Insurance companies *must* be able to prove to that they have a large enough **reserve** to remain in business responsibly, as well as be able to prove they will have enough revenue coming in over future years to sustain their **reserves**. Companies have **revenue** from **Premium** payments and from investment earnings. The Insurance Commissioners of each state use the *Commissioner's Standard Ordinary Mortality Table*–the **CSO Table**. This is a standardized mortality table that uses **higher** mortality rates to make sure insurance companies have sufficient **reserves** on hand to pay out death benefits. Having sufficient **reserves** is a **legal requirement.**

# Dividends

**Objectives . . .**

This Unit will cover a different aspect of Life Insurance: Certain Life Insurance policies pay Dividends. These are known as participating policies, and policyowners can look forward to sharing in the surplus of the company. In this Unit we will examine the sources of Dividends, how Dividends are paid (options), and how a company determines the amount of Dividend to be paid at the end of a year.

Simply put, a dividend paid on a life insurance policy, is the return to a policyholder of an overcharge by the company.

## SOURCES OF POLICY DIVIDENDS

The three sources of Policy Dividends are:

- Mortality
- Operating expenses of the insurance company
- Assumed interest

**Mortality-** The mortality table insurance companies use tell them how many people of a certain age group are likely to die in every given year. So, if *fewer* people die than the mortality tables predicted and the insurance company forecasted, then the Life Insurance company has **a savings in mortality** because they have paid out less claims than expected over the year.

**Operating Expenses-** These costs include payroll, rent on buildings, maintenance, commissions, and the like. These costs–for every

business–are mostly predictable. So, if an insurance company experiences a decrease in overhead expenses (new leases, equipment savings, better business practices) the insurance company will experience **a savings in operating expenses**.

**Assumed Interest-** This reflects the amount of interest an insurance company earns over a year. Insurance companies forecast a certain interest percentage earned on their investments–say 5% annually. However, if the insurance company gets a 6% return on their invested premiums, the additional earnings would provide more surplus for dividends.

## DIVIDEND OPTIONS

The following are ways policyowners can elect to receive Dividend payments.

**Cash Dividend Option-** This is the option in which the policyowner receives a check for the **Dividend** amount from the insurance company.

**Reduced Premium Option-** Rather than receive a check, this option allows the policyowner to apply **Dividends** towards reducing the amount of their next premium payment.

**Accumulate at Interest Option-** This allows a policyowner to leave their dividend payments with the insurance company to accumulate and earn interest. If the insured dies with accumulated **Dividends**, then they are paid to the policy's beneficiaries, *including* the interest

that accrued on the investment. **It is important to note that the interest (not the dividend itself) is taxable**.

**Paidup Additions Option-** Policyowners can use **Dividend** payments to **purchase additional life insurance**. The amount is based on the **Dividend** payment and the insured's age at the time they purchase the additional coverage. The additional amount of insurance is the same type as the original policy and does not require proof of insurability.

**1 Year Term Option-** This option allows the policyowner to use **Dividend** payments to buy term insurance. This additional coverage would be in effect for one full year.

## DETERMINING DIVIDENDS

The Board of Commissioner's decision regarding **Dividends** is declared each year, the amount based on their surplus and how the company did during the year. The insured can elect to set up a **Dividend** option as a permanent thing to be dispersed automatically when there is a **Dividend** available on the policy.

# Settlement and Nonforfeiture Options

## SETTLEMENT OPTIONS

It is common for most Life Insurance policies to pay out policy proceeds in a ***lump sum , one cash payment to the beneficiary*** of the policy. But there are other payment options available that may better fit a beneficiaries needs. A lump sum payment may not be

managed properly, tax issues may arise, or a lump sum pay out might not fit the beneficiary's long-term needs.

**Settlement** options may avoid these issues and guarantee the money will earn interest, and installments can be arranged to fit the beneficiaries needs. While a policyowner has the option of deciding on a **Settlement** option when the policy is originated, it is often the beneficiary that may choose an option.

**Settlement Options** include the following:

- Life Income Option
- Interest Option
- Fixed Period Option
- Fixed Amount Option

## LIFE INCOME OPTION

As the name of this option implies, this provides a lifelong income for the beneficiary. These payments are similar to annuities. A **Lifetime Income Option** will pay the beneficiary a guaranteed income for as long as they live.

## INTEREST OPTION

With this option, the life insurance company retains the proceeds of the policy and invests them, then pays out the interest earned on the principal as an income. The beneficiary may retain the right to withdraw the full amount at any time, or it can be arranged so that the beneficiary cannot withdraw the full amount until a certain amount of time has passed, or reaches a certain age.

**FIXED PERIOD OPTION**

The **Fixed Period Option** pays the beneficiary a guaranteed amount, based on the principal and its interest earnings, for a certain time such as over five years, or over ten years. The amount of the payment depends on the principal amount, the length of time these payments are to be made, and the interest earned. Like the previous options, if the *primary beneficiary* should die, then the payments may be made to a *secondary beneficiary.*

**FIXED AMOUNT OPTION**

Under the **Fixed Amount Option**, the beneficiary chooses the amount of the income desired. Payments at that amount will continue until the combined principal and interest is exhausted. Again, these payments depend on the original principal, interest, and the amount of each specified payment.

## NONFORFEITURE OPTIONS

A good place to begin when discussing Nonforfeiture Options is the ***Standard Nonforfeiture Law****.* This law states that any cash value accumulations in life insurance policies must be available to the insured even if the policy is allowed to lapse or premium payments are no longer made. Before the *Standard Nonforfeiture Law*, these accumulated cash values were simply given up when the insured allowed a policy to lapse. A schedule is provided in the policy to indicate these values at any given year.

The **Three Nonforfeiture Options include**:

- Cash Surrender Value
- Reduced Paid-Up Insurance
- Extended Term

**CASH SURRENDER VALUE**

The **Cash Surrender Value Option** allows the policyowner to request in writing, the policy's cash value by returning or “surrendering” the policy to the company. It is important to note that when a policy is surrendered, the policyowner is ***NO*** longer covered by the insurance and they will be paid the surrender value of that policy less any outstanding policy loan amount.

**REDUCED PAID-UP INSURANCE**

The **Reduced Paid-Up Insurance Option** allows a policyowner to use the cash value of an existing policy to purchase **a single premium policy for a reduced face amount**. This amount is based on the insured's attained age at the time of election. No further premiums need be paid on this policy, as it's a **"Paid-Up"** single premium policy. Also, the new policy will continue to retain and build cash value. These **Reduced Paid-Up** policies are the same type of insurance as the original policy, *excluding* any riders and policy loans. **This is the automatic option on any special class or rated policies.**

**EXTENDED TERM**

The choice by default if cash surrender or reduced paid up is not elected (except for above), this option allows the company to continue the original face amount of insurance  by using the policy's cash value

to buy term insurance. With **Extended Term**, the length of the term is based the cash value and the insured's attained age.

**Simply stated . . .**

If a policy is allowed to lapse and has cash value, and the policyowner does not reinstate the policy, or request a cash surrender or a reduced paid up policy, the insurance company will automatically extend the same face amount for a certain length that is specified in the. If there were an outstanding policy loan, that amount would be deducted from the value of the policy.

# Policy Loans

**Objectives . . .**

In this Unit we will cover Life Insurance Policy Loans. We will discuss the different ways in which loans can be taken out on a life insurance policy, how a policyowner can benefit from taking out a Policy Loan, and the overall effects a Policy Loan has on a Life Insurance Policy. Also covered will be the Interest Rates associated with Policy Loans, as well as how businesses can use Policy Loans.

## THE BASICS OF POLICY LOANS

**Policy Loans** can only be taken out by the policyowner (you'll remember that the policyowner and the insured can be two different people). *Only permanent policies that build a cash value* (Whole life, Universal, etc) may be borrowed against. The insurance company gives the loan with the cash value of the policy as collateral. **No other form of collateral is necessary**. A Policy Loan requires **no credit**

**check** and is completely confidential. **No cosigner** is needed, and the policyowner may **choose a loan repayment schedule** that benefits them. It is important to note that ***any*** **unpaid Policy Loans are deducted from the death benefit of the policy should the insured die.** That unpaid loan amount would *decrease* the amount the beneficiary would receive.

### DEFERMENT OF POLICY LOANS

Although it is rare, an insurance company may **defer** making a **Policy Loan** for up to 6 months from the time of application for the loan. An exception would be an ***Automatic Premium Loan Provision***, which states the insurance company will automatically lend the policyowner the amount of a past due premium (see Unit 6-Policy Provisions).

### POLICY LOANS AND IRREVOCABLE BENEFICIARIES

An **Irrevocable Beneficiary** is one that cannot be changed by the policyowner, unless they have the **Irrevocable Beneficiaries'** permission. The policyowner also gives up certain rights about the policy, and most policy rights cannot be exercised without the permission of the **Irrevocable Beneficiary.** This includes **Policy Loans.** The policyowner must have the permission of the **Irrevocable Beneficiary** to take out a **Policy Loan**, and they *must* provide written permission to the insurance company. The only exception would be if the loan were to pay a premium on the policy.

## NONPAYMENT OF POLICY LOANS

When the policyowner takes out a **Policy Loan** and continues to make premium payments the policy's cash value will continue to build. However, if the premiums are *not* paid (and there is no Automatic

Premium Loan Provision) the policy will lapse. The **outstanding loan amount would then be deducted from any policy cash value** requested by the policyowner.

**If the annual interest on the loan is not paid each year, it is added to the principal balance** and the loan and its interest could become greater than the cash value of the policy. This will cause the policy to lapse. The insurance company is required to alert the policyowner of this occurrence by letting them know the policy is in danger of being cancelled. In this situation, a policyowner could pay enough of the loan and it's interest to lessen the *total outstanding amount* in relation to the total cash value of the policy.

**NONFORFEITURE**

As discussed earlier, any outstanding loan and interest amounts are deducted from the cash value of a policy if a policyowner surrenders the policy. But if the policyowner chooses the **Reduced Paid-Up option**, then the outstanding loan amount, plus interest, is deducted from the cash value of the policy and only the remainder is used to purchase a reduced amount. As always, the **insured's age** at this time is factored in to the amount of coverage that can be purchased.

**DEATH CLAIMS AND POLICY LOANS**

Before any death claim is paid to a beneficiary, **any outstanding loan amount is deducted from the proceeds**. (Any outstanding loan interest would also be deducted).

## POLICY LOANS AND INTEREST

While the **interest rates** of **Life Insurance Policy Loans** are typically lower than those charged by banks and other lending institutions, it is important to discuss why interest is charged on **Policy Loans**. A **Policy Loan** reduces the amount of cash an insurance company has to invest therefore the amount of return earned by an insurance company is *lessened*. Without making up for this loss of income a company would be unable to meet it's financial obligations.

Insurance companies may charge **interest** in 3 different ways:

- Variable Interest Rates
- Fixed Interest Rates
- Universal Life Interest Rates

## VARIABLE INTEREST RATES

With a **Variable Interest Rate**, the insurance company determines the loan interest rate that will be in place towards the loan for the upcoming year. This rate is connected to *'Moody's Corporate Bond Yield Average: Monthly Average Corporate Yield.*' This is a legally mandated index concerning the maximum **interest rate** that can be charged. This maximum rate can vary from state to state.
In regards to a **Policy Loan**, the **Variable Interest Rate** *must* be stated in the original policy when it is issued.

## FIXED INTEREST RATES

A **Fixed Interest Rate** is one that is always the same on the loan amount, usually from 6-8% annually. It cannot be changed in any

way. This **Fixed Interest Rate** *must* be stated within the original policy at the time it is issued.

### UNIVERSAL LIFE INTEREST RATES

Policyowners with **Universal Life** policies may also take out **Policy Loans**. The loan is made against the accumulation account of the policy, less any surrender charges. **Interest rates** on **Policy Loans** for **Universal Life** policies may be either fixed or variable, the cash value of the policy will continue to earn. This results in a low net cost.

**Real World . . .**

Imagine walking into a bank where you had a savings account with $10,000 dollars in it. If you asked to borrow $10,000 and used the savings account as collateral, as you would expect, the bank would continue to pay interest on the money in your savings and charge you interest on the loan. (There is of course, the required loan application, credit check, and loan repayment schedule not needed for a policy loan).

## POLICY LOANS AND BUSINESSES

Businesses may use **Policy Loans** to provide cash for *buy-sell agreements,* and other business endeavors. The policy proceeds or cash value of a life insurance policy taken out on a business owner or other key executive may be used to meet future needs of the business. When a business takes out a **Policy Loan,** it is subject to the same rules as an individual policyowner. Any outstanding loan and interest amounts would be deducted from the death benefit or the cash value of the policy should it lapse. However, s*pecial tax rules* may apply to businesses and **Policy Loans.**

## ***END SECTION***

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes A red flashing button will warn you.**

# Section LO 4

# Applications, Underwriting & Claims

**Objectives . . .**

The **application** not only begins the process to provide an individual with coverage, but there are also crucial legal aspects to the **application for insurance**. As a licensed agent, accurately completing the application is an important step in developing long-term and enriching relationships with your customers, and to your career. So, do not take this Unit lightly. Take notes and remember: this is what you will actually be doing once your career as a licensed agent begins.

## APPLICATION FOR LIFE INSURANCE

The agent completes the **application** as they question and converse with the applicant. The applicant is the person asking the company for insurance. Remember, *the applicant is not necessarily the individual who would be insured.* At this point, that person is known as the **proposed insured**. The insurance company will determine if the person will be insured, by the information on the **completed application**. Again, it is crucial that both the agent and the applicant

fill out the application accurately and completely, ***to the best of his ability***. The **application will become part of the legal contract of the policy** and be a physical part of the policy itself. The applicant must sign the application, stating that they have provided accurate information to the best of their knowledge. The agent must also sign the **application.** It is important to note that most **applications** contain space for additional comments from the agent during the customer interview process. This is referred to as the ***agent's statement or agent's report*** where he is duty bound to report any observations or suspicions.

What type of information is on the application? This varies form company to company, but applicants will mostly provide information on date of birth, height, weight, lifestyle habits and financial information such as income and net worth. Answers the applicant provides may indicate that additional information may be required by the company to make an underwriting decision. A questionnaire regarding specific details of a medical condition such as asthma, or a hazardous sport such as skydiving or scuba diving, completed and signed by the applicant is a common request.

**MINORS**

Individuals under the age of 18 cannot enter into a legally binding contract. A person is considered a minor–for the purposes of life insurance–until they have reached the age of 15. If the individual is under the age of 15 (or, some insurance companies even if they are older than 15) the **application** must be signed by a parent, grandparent or legal guardian who is the owner of the policy.

## CORRECTIONS / CHANGES

Any mistakes or ***changes*** that are corrected on the **application for insurance** must be done by the agent and **initialed by the applicant**. This is true for any mistake or omission. A mistake on an application could be costly to the agent, the customer and the insurance company. It could result in improper premiums being charged or incorrect and insufficient coverage being supplied to the customer. It is the *total responsibility of the agent* that the application is delivered to the insurance company **completely and accurately**. Incomplete or incorrect applications can be cancelled or voided by the insurance company before the policy's incontestable clause comes into effect.

**The Agent World . . .**

You have a legal duty to be sure that each application for insurance is completed fully without deceit. The information on all forms must be accurate and to the best of your knowledge. In Bitz vs Knox, an agent was sued for inadvertently submitting erroneous financial information. In Lewis vs Equity, the client alleged the agent filled out the application and failed to list the clients many heart-related treatments. The courts awarded punitive damages to the client. In Life Investors vs Young, a life insurance company sued it's own agent for $26,000 when he failed to indicate a known pre-existing heart condition on an application. In American vs Hollins it was determined that the client lied about her pre-existing condition. But, because the agent was in charge of the application the policy could not be voided. Problems ensured for both the insurer and agent. And, in Malonev vs Basey, one of the application pages failed to transmit over a fax machine. A claim was filed and the company denied coverage due to an incomplete application. The agent was in the middle of a big dispute between his client and carrier.

## REPRESENTATIONS, MISREPRESENTATIONS AND WARRANTIES

A **representation** (including **ALL** of the statements made on the application) is a statement an individual has made and believes to be **true and correct to the best of their knowledge**. It is considered to be a **representation** of the truth.

A **warranty**, however, **is a statement made that is guaranteed to be true.** It is important to note that no statement made on an application for life insurance is considered to be a **warranty**.

A **misrepresentation** is the presentation of false information by the proposed insured or applicant. It is considered *fraud* when the **misrepresentation** is an intentional effort to gain an advantage, and results in a loss by the insurance company. There is a major difference between an honest mistake and an intentional *fraud*.

**Concealment** is a term closely related to misrepresentation and is the **withholding of information** from the agent or insurance company that would be a material factor in determining if coverage would be provided.

**The Agent World . . .**

What information must agents disclose? Anything you know to be untrue, misleading or material to the risk that an insurer will rely upon to approve coverage you must disclose. Insurers can use agent misrepresentations to deny coverage, making you . . . the agent . . . liable as the insurer! Or, an insurance company can use agent negligence as a defense against paying a claim, leaving the agent holding the bag as happened in Ward vs Durham Life where an agent told a client and his wife to leave out critical pre-existing health information on an application. When the client died, the insurer denied coverage and the agent was sued.

## CONDITIONAL RECEIPT

Once the application has been completed accurately and fully by the agent, they usually then collect the first policy premium payment and issue a **conditional receipt**. Even though the policy has not yet been approved and issued, the agent still collects the payment.

The **conditional receipt** serves four functions as it:

g) States that the policy will be issued if approved by the insurance company
h) Serves as a receipt for the first full premium and acts as a temporary policy
i) States the conditions that the policy *will pay out* should the proposed insured die before the policy is issued, if the policy *would have been approved* by the insurance company
j) States that the policy *will not pay out* should the proposed insured die before the policy is issued, if the policy *would have not been approved* by the insurance company

With payment of the first premium and issuance of the **conditional receipt**, coverage may begin immediately, as long as the policy is later approved. If the policy is denied, the customer is notified immediately and is given a full refund of the payment.

A binding receipt and/or a written binder, is not used in life and disability insurance.

## POLICY EFFECTIVE DATE

The **policy issue date, or effective date** is the actual day the policy begins providing full protection. The policy's incontestable clause is also based upon the **policy effective date**. Also, the policy's suicide clause is based on the **policy effective date**. This date must be made clear to the insured because so many important matters are based on this date.

The **delivery date of a policy** is important with regard to many of the disclosures mentioned below. **It is from this date that any free look period begins.** Delivery of a life insurance policy should always be **in person**. It is an opportunity to review the policy, answer any question, make any changes, and to build on the client relationship, a key aspect of **policy retention** and multiple sales opportunities for the agent, the company, and of course the client, who benefits from the insurance protection. If not practical, delivery may also be **by registered or certified mail**.

**REPLACEMENT**

State regulations are in place to protect insurance consumers in transactions that involve the **Replacement** of a life insurance policy or annuity. **Replacement** refers to any transaction involving a policy being lapsed, surrendered, or borrowed on to purchase new insurance. The laws involving **Replacement** are meant to regulate the activities of insurance companies and their representatives, to **protect the insurance buying public** by establishing minimum standards of conduct, and to insure that an insurance consumer receives timely and accurate information so they may make an informed decision that is in their own best interest. **Replacement** regulation also reduces the risk

of misrepresentation or lack of disclosure. Finally, these regulations establish the penalties for failure to comply.

**Replacement** regulations require an agent (and company) who replaces or offers to replace an existing policy, to provide the policyholder with written, signed, and dated documents, comparing the terms, conditions and benefits of an existing policy with the proposed new policy.

**Replacement** is defined as; the purchase of a new life insurance policy or annuity when a current policy or annuity is going to be:

- Lapsed, surrendered, partially surrendered, forfeited, or otherwise terminated
- Changed to lower the policy's term or benefits
- Reissued with a reduced policy cash value
- Converted to a nonforfeiture benefit
- Used in a purchase with money withdrawn, borrowed or obtained from the surrender of an existing policy

Any company that is replacing the policy of another must notify the existing company of the **Replacement** within 3 days of receiving the new application for insurance. The new insurance company must also keep the notice of replacement for *at least* 3 years or until their next Insurance Division audit. The insured must also be provided with a **30-day Free Look provision**.

It is important to note that there are *5 important Exemptions* where **Policy Replacement** regulations do not apply:

- Credit Life Insurance
- Group Life Insurance or annuities
- When the existing policy is being replaced by the same insurance company
- A policy that is used to fund a pension or other retirement plan
- A new policy that is entirely paid for by the insured's employer

## DISCLOSURES AND AUTHORIZATIONS

Insurance producers and companies are required to provide certain **Disclosures** to potential buyers of insurance. The purpose is to avoid any confusion or misrepresentation on the part of the insurance company or it's representatives. The buyer must be made fully aware of what type of insurance they are considering and the type of policy they might buy. In order to make sure this happens, an insurance company must provide a prospective buyer with:

- A Buyer's Guide
- A Policy Summary
- Policy Illustration with Cost Comparison Indexes

### BUYER'S GUIDE

This is an informative booklet that helps the potential customer make good decisions about what type of insurance they need, how much insurance they need, and allows them to compare the costs of the different types of policies they are considering. The **Buyer's Guide** also clearly defines **Whole, Term and Universal** Life policies. The company must provide the potential customer with a **Buyer's Guide** at policy delivery or when requested.

**Comparing Life Policy Costs** -- When evaluating policies, it is not enough to simply compare premiums. A lower premium does not automatically mean a lower-cost policy. So ***cost indexes*** have been developed to help measure and compare policies. Policy illustrations should include Surrender Cost Indexes and Net Payment Cost indexes over a 10-year and 20-year period, accumulate annual cash dividends at 5% to the end of the period. They should show average annual costs and payments per $1,000 of coverage. ***Cost indexes*** such as these can be quite valuable when shopping for life insurance as long as numbers are compared for similar types of insurance plans. Additionally, special policy features, customer service and company financial strength should be weighed when considering the best choice.

**Surrender Charges & Surrender Period**

Agents should fully inform their clients about any potential surrender charges and the periods during which they apply. California requires individual annuity contracts for seniors to contain a disclosure regarding surrender charge period, unless the contract does not have these charges.

## POLICY SUMMARY

A **Policy Summary** is a separate written document that describes the specific elements of the insurance policy. The **Policy Summary** must contain the following 8 items:

- A clearly placed title such as, "**STATEMENT OF POLICY COST AND BENEFIT INFORMATION"**
- The name and address of the agent and the insurance company
- The generic name of the type of policy (e.g. term, whole life, etc.)
- With respect to the first 5 years of the policy, the annual premiums, guaranteed amount payable upon death, the total guaranteed face value, the guaranteed cash surrender value, the cash dividends due to the policyowner annually, and any guaranteed endowment amounts
- The annual percentage rate that would be charged on any **Policy Loans**

- The Surrender Cost and Insurance Net Payment Cost Indexes for 10 and 20 years
- A statement to the effect that an explanation of the intended use of these indexes is provided in the **Buyer's Guide**
- The date the **Policy Summary** was prepared

Like a **Buyer's Guide**, a **Policy Summary** must be provided to any prospective customer at policy delivery or upon their request.

## POLICY ILLUSTRATIONS

**Policy Illustrations** may be of 3 types:

- Basic Illustration
- In Force Illustration
- Supplemental Illustration

A **Basic Illustration** is a proposal that shows the both the policy's **guaranteed and non-guaranteed** elements.

A **Supplemental Illustration** is usually provided in addition to the Basic Illustration. It can only show non-guaranteed policy elements that are similar to the **Basic Illustration**.

An **In Force Illustration** is provided to the policyowner at any time the policy has been in force for more than one year.

**Guaranteed elements** include the premiums, death benefits, cash values and riders that are established and guaranteed when the policy is issued.

**Non-guaranteed elements** include the premiums, death benefits, cash values and riders that are shown by illustration over a number of years and are not guaranteed when the policy is issued.

ALL **Policy Illustrations** must be clearly labeled 'Life Insurance Illustration' and must include:

- The name of the insurance company/provider
- The name and address of the insurance company/provider
- The name, sex, and age of the proposed insured
- The rate classification under which the illustration is based (e.g., smoker, non-smoker)
- The generic name of the policy, form number and company product name
- The initial death benefit
- Any dividend option if applicable

Life insurance policies that use illustrations must also include annual reports that show the following:

- Annual premiums
- Current dividends
- Current death benefits
- Outstanding loan amounts
- Current cash surrender values
- Application of current dividends

It is important to note that any interest rates used in an illustration cannot be higher than rates currently being offered by the insurance

company. If a **Policy Illustration** is used, the insurance company must keep copies, including any revisions or updates, for at least 3 years after the policyowner terminates the policy.

When a **Policy Illustration** is to be used during any sales presentation of a Life Insurance policy, the insurance company, or it's representative, may not:

- Claim or mention that the policy is anything but a Life Insurance policy. Prohibited are claims of it being an 'investment' or a 'retirement savings account'
- Mislead or describe that any non-guaranteed elements in the policy are actually guaranteed
- Use or make reference to any **Policy Illustration** that does not comply with state laws and regulations
- Provide or show any incomplete illustrations
- Use the term 'vanishing' or 'vanishing premium', or any term that implies the policy becomes paid up or that future premiums can be paid by non-guaranteed elements
- Use a **Policy Illustration** that shows policy performance as more favorable to the policyowner than the insurance company's illustrated scale
- Use a higher interest rate to increase cash value or other non-guaranteed elements than the insurance company's underlying rate scale

**Regulations** concerning **Policy Illustrations** applies to all life insurance policies *except* for the following:

- Variable life insurance
- Group term life insurance
- Credit life insurance
- Individual and group annuity contracts
- Any life insurance policy with a face value of less than $10,000

Any **Policy Illustration** used in a sales or marketing presentation must also be signed and dated by the potential insurance consumer to indicate that the illustration has been explained to them and they understand it.

## COST COMPARISON INDEXES

The **Cost Comparison Indexes** show the cost of the benefits provided in an insurance policy. These indexes factor in the concept of the **time value of money**. For instance, a lower cost index would be a sign of lower costs for the benefits being paid for. These indexes are useful when comparing similar policies. Generally, there are 2 types of indexes used.

A **Net Cost Comparison Index** is useful if the buyer's main concern for the policy is the benefits paid at the time of death. The level of the policy's cash value is of secondary importance. This index helps compare costs at a future time, usually 10 or 20 years ahead. These predicted amounts are based on the premiums being paid and no cash values being taken from the policy.

A **Surrender Cost Comparison Index** is useful if the level of the cash value of the policy is the more important concern. This index helps the buyer compare costs if in the future (again, 10 or 20 years)

the policy was surrendered for some reason and the cash value of the policy taken.

If the application for insurance includes a request for certain riders, additional signed disclosure is required for the following;

**Accelerated Benefit Rider Disclosure –** provides a disclaimer regarding any tax consequences, possible loss of any state or federal benefits such a Medicare or Social Security, and a reduction in death benefit.

**Critical Illness Disclosure –** in addition to the notices, it also provides a definition of covered and not covered conditions under the rider as well as exclusions and limitations.

## AUTHORIZATIONS

Disclosure may also be considered to include any required **Authorization** forms for the release of any personal, financial, or medical information to be used in the underwriting of the applicant for insurance with the applicant's signature.

In addition to the signed application as consent and disclosure, there are supplemental forms including:

**HIPAA Authorization for Release of Medical Information –** The HIPAA Privacy Rule (2002) requires compliance in protecting the health information of individuals by health care providers. Release of any medical information by them, including to an insurer, require a signed release.

**HIV and AIDS Discrimination –** Due to medical advances, the longevity of HIV and AID's infected individuals is prolonged. While insurers can still decline an application on the basis of a positive ELISA test (the HIV test), they cannot indiscriminately test for HIV without the informed consent of the applicant (see below). Once a test has been conducted, the insurer must maintain strict confidentiality regarding the results.

**Notice and Consent (State Specific) –** Requires insurance applicants to be advised of any blood testing for HIV in determining insurability, and to choose the disclosure of HIV positive results, with a signed notice and consent form approved by the state insurance department.

**Genetic Testing –** insurers cannot indiscriminately test for an applicant's ***genetic disposition or characteristics*** (genes known to cause a disease) for disease without informed consent. Results must be handled in a strict and confidential manner.

**Authorization to Obtain and Disclose Information (State Specific) –** A predecessor to the HIPAA form, this signed release may be still be required in many state jurisdictions.

## LIFE SETTLEMENT DISCLOSURES

At the time of application, agents transacting a life settlement must suggest possible alternatives (keeping the policy in force, seek an accelerated death benefit, assign the policy as a gift, covert a term policy to whole life, reduce the death benefit for lower premiums or lapse or surrender the policy), tax implications, creditor rights, inability to buy future life insurance, possible effects on conversion rights,

rescission rights (cancel the deal –typically 15 days) , date when funds will be available, the requirement to disclose medical, financial and personal information and the fact that the insured will be contacted perdiodically to determine health status.
At the time of offer, a life settlement transaction must disclose the affiliations between broker and provider as well as provider and issuer, certain provider disclosures such as gross purchase price, amount paid to policy owner, and compensation to brokers and any other parties. Brokers must be certain to disclose a description of all offers, the affiliation between broker and the person making the offer and all estimates of life expectancy.

## DO NOT CALL LIST

The Federal Trade Commission (FTC) amended the Telemarketing Sales Rule to give consumers a choice in receiving telemarketing calls.

Effective October 1, 2003, it is illegal to call a number listed on the National Do Not Call Registry. (Many states have established similar laws). Solicitation of names and telephone numbers should be "scrubbed" against the Do Not Call List by the list provider, or by the company you are calling on behalf of. A violation of the law provides for a civil penalty. It is not a violation to call an existing customer.

# Underwriting

**Objectives . . .**

This Unit will cover some of the actual day-to-day functions of your career as a licensed insurance agent. Field Underwriting is the most direct way for you to positively influence and improve the lives of potential customers. We will discuss basic definitions and principles of Field Underwriting, as well as several resources you will have to help you make good decisions about underwriting policies

## Legal Relationship and Responsibilities

An agent appointed by an insurance company is **acting on behalf of the company** when soliciting, selling, and servicing insurance with the public. The agent is considered to be a **fiduciary**, that is, in a position of trust and as such, he must act in good faith in dealings with the public, as well as insurers.

**Responsibilities to an insurer** include;

- a duty to the insurer
- conducting themselves prudently
- remitting all monies promptly
- completing applications accurately
- disclosing all information to the insurer
- delivering the policy
- obeying insurance laws

**Insurer responsibilities to the agent** include;

- act in accordance with agent contract
- paying all compensation due
- informing the agent of product changes

The agent also faces responsibilities **to the insurance buying public** including:

- soliciting applications
- explaining coverage

- assessing needs
- putting the client interest first
- providing service and reviews
- protecting confidences

**Underwriting** determines which individuals are acceptable to insure, according to the company's standards. Selling a policy to just anyone would be profitable in the short term, but **adverse selection** would make it disastrous in the long term. So, **Underwriting** provides insurance companies with methods to determine **who can be insured**.

Initial, or ***field underwriting***, begins before the application with the agent and *preselection,* whereas *postselection* underwriting is done after the application is submitting for underwriting by the company.

**Sources** of underwriting information are covered later in more detail but include;

- Application
- MIB
- Consumer reports
- Driving records
- Medical exams
- Physicians reports

**Agent's, The Insurance Application & Underwriting**

As a fiduciary of the insurance company, it is the agent's responsibility to fill out the application ***accurately and truthfully*** to the ***best of his ability***. The ***agent report*** or statement on the application should be the place where the agent comments on any observations about the applicant.

Agent's also need to know that ***basic underwriting requirements will vary based on the company***, i.e., there is NOT one way to process an applicant.

## RISK SELECTION

Important to successful **risk selection** and the ***prevention of adverse selection*** are 8 factors insurance companies use to determine **insurability:**

- Age
- Occupation
- Medical history
- Lifestyle
- Place of Residence
- Financial condition
- Physical condition
- Moral condition

***Age*** concerns the age of the proposed insured. This, of course, has to do with how many years the individual is likely to live. By using mortality tables, companies are able to determine how likely a person of a certain age is of dying within the next year.

***Occupation*** is the type of work a person does. A teacher would be considered to have a less hazardous occupation than a construction worker.

***Medical history*** is the record of the person's past health. Chronic ailments could be a factor in the determination of a person's insurability. Medical questions are asked and answered by the applicant. Depending on the applicants age and the amount applied for, the application could be **"non-medical"** though a company reserves the right to request a medical examination before issuing a policy.

**Attending Physician's Statement** – a report requested by the insurer but filled out by a physician, hospital or medical facility who has treated or is treating a proposed insured. It is a summary of all pertinent medical conditions, illnesses and treatments of the insurance applicant. Inconsistent or missing information will compromise the risk analysis process. An applicant or APS that reveals a condition needing more information can delay approval of the policy pending confirmation and possible rating of the proposed insured.

**Additional Risk Exposures May Require More Info**

If an applicant reveals certain health conditions or other risk exposures in the process of applying for insurance, additional information may be needed in the form of:

- MIB Report (Medical Information Bureau – see below)
- Attending Physician's Statement (see box above)
- Credit or inspection reports
- Department of Motor Vehicle (DMV Report
- Hazardous Activity Questionnaire (activities like scuba diving, aviation, etc)
- Additional Medical testing (EKG, treadmill, additional blood tests, physician exam, etc.)

***Lifestyle*** factors in dangerous hobbies (e.g., deep-sea diving, private pilots, mountaineering).

***Place of Residence*** is important to determine insurability because of the negative health effects that are sometimes associated with living in underdeveloped countries.

***Financial condition*** is simply the proposed insured's ability to pay premiums, along with all other bills. A large life insurance policy would lapse if the insured were unable to pay the premiums over a long period of time.

***Physical condition*** takes into consideration the person's overall health at the time of application for insurance.

***Moral condition*** typically concerns the known use of illegal drugs, which would be a factor in the proposed insured's moral condition as well as their insurability.

## MEDICAL INFORMATION BUREAU

There are many external organizations that provide insurance companies with information about those who apply for Life Insurance. The **Medical Information Bureau** is an association of several hundred life insurance companies that stores information about any person who applies for insurance. The information reflects the person's health and physical condition.

The **MIB's** main purpose is to lessen the effects of *misrepresentation, fraud and withheld information*. This sort of information is also stored by the **MIB**. However, there are four procedures the **MIB** and insurance companies must follow in order to protect the person's right to privacy:

k) The insurance company *must* notify the applicant in writing that they may report their findings to the MIB

l) The MIB *must* have authorization from the applicant to provide information to other member insurance companies

m) The individual may request *in writing* that the MIB disclose any information in their records

n) The applicant *must* be made aware that an application for coverage or a claim may cause the MIB to supply any information to another member company.

## FAIR CREDIT REPORTING ACT

Being like any other consumer, an applicant for insurance is entitled to the protection and rules of the **Fair Credit Reporting Act.**

**Fair Credit Reporting Act requirements:**

- The insurer has to get the applicant's consent before obtaining medical information.
- The insurer has to give the applicant written disclosure within **3** days of requesting a consumer report.
- If the insurance coverage is denied because of the consumer report, the consumer can find out what that information is, just in case it's inaccurate.

If the person receives an adverse notice report, that report has to include:

- The contact information for the consumer reporting agency
- A legal statement that the consumer reporting agency didn't have anything to do with the person getting denied for insurance
- A notice that the applicant has the right to dispute the information in the report. Upon request, the consumer reporting agency (NOT THE INSURER) will then supply the person with a free copy of the report within **60** days

## RATINGS & UNDERWRITING OUTCOMES

Even if a person is determined to be a high risk, many insurance companies will still be able to offer some kind of policy. Common sense dictates that a healthy person (no illnesses, non-smoker, non-hazardous occupation, healthy life habits) will probably be offered a policy with a lower premium than a person who is determined to be unhealthy (smoker, history of heart disease). An applicant that is accepted "as submitted" is a **standard risk,** a healthier individual would be a **preferred risk**, while the unhealthy person would be considered a **substandard risk.**

**Underwriting Outcomes**

When underwriting reveals the need for additional information or a new rating, the outcome can be different than the original application or quote suggested:

- ***Insurers*** can raise premiums to account for the higher risk, require additional tests, waive a rating requirements or refuse coverage.
- ***Insureds*** might pay additional premiums for their coverage, submit to additional tests / inquiries or cancel their application.
- ***Agents*** may be required to assist with additional investigations. A higher risk and associated higher premium may risk the agent's business for this client.

Insurance companies may issue the substandard risk a ***rated policy***. A rated policy is one that takes into account the higher risk the insurance company is taking by issuing a policy to this person. The premiums on this policy would be higher. An insurance company may add a **flat extra premium charge**, which is a flat charge to the premium that may be permanent or temporary with respect to the life of the policy. Or, they may use a **multiple table extra premium method**. This method would cause the high risk to pay a percentage higher of the standard established premium rates. For example, a

standard risk is assigned a 100% rate. A substandard risk, given a 150% rating, would pay 1.5 times the standard established premium rate. The third option is called a **lien plan**. Lien plans reduce the death benefit of the policy in the early years based on the proposed insured's risk. Then the insurance company places a lien against the policy, stating that if the death occurs within this lien period, the face value of the policy will be reduced by the amount of the lien.

**The Component's of A Policy's Premium** – Underwriting and ratings are just one part of the process that determines premiums. Other factors include:

***Mortality*** – more deaths than expected can create upward pressure on premiums.
***Insurer Expenses*** – higher costs than projected influence the bottom line and the need for higher premiums.
***Investment Return*** – poorly performing investments can haunt the ability to pay claims and create a need for higher premiums.
***Reinsurance*** – the ability to transfer risk to other insurance companies can be critical to proper reserves, claims and the need for more premium income.

**EXCLUSIONS** An insurance company can still insure a person who is classified as a substandard risk by attaching an **exclusion or rider** to the policy that eliminates the specific high risk element. The policy would then only cover normal risk losses. Examples of specific high risks could be a hazardous occupation or hobby.

## INSURABLE INTEREST

In cases where the individual being insured is different than the person applying for insurance, **insurable interest** must be present at the time the policy is issued. It's not difficult to imagine how dangerous or unethical things could occur if one person takes a life insurance

policy out on another. Murders and other terrible acts could be committed, as beneficiaries stand to make a lot of money upon the benefit pay out.

Insurance companies will consider the applicant's **insurable interest** before insuring another person's life. This is the applicant's ***interest that the insured remain alive***. Examples of this are usually 'love and affection' or other economic factors.

**Requirements For Insurable Interest To Exist**

***Policyowners*** – Policyowners must have an insurable interest in the insured at the time the policy is issued. A person always has an insurable interest in his own life. So, a man can buy a policy on himself and name any beneficiary (even pets). But to be a policyowner on another life, there must be insurable interest by blood or law, e.g., husbands and wives, parents and children, brothers and sisters, business partners, creditors, etc. . . . all can be policyowners.

***Beneficiaries*** – At the time a policy is issued, a designated beneficiary (someone named by the owner) has an insurable interest in the policy by the shear fact he is named. However, for someone to purchase a policy on the life of another and be named as a beneficiary, there must be insurable interest with the insured by blood or law.

***Facility of Payment*** – a relative or any other person that incurred expenses on behalf of an insured could have insurable interest and be paid by an insurer, e.g., a non-family person paid for all of the insured's funeral expenses.

Examples of insurance interest include the following

- A person who applies for a policy on their own life
- A person's spouse, child, parent or other close family member
- The owner of a business, a partner or other important employee
- A creditor or associated debtor (only for the amount of the debt)

**CONSENT** Obviously, a person applying to insure another person must have that individual's **consent**. The person who would be insured is required to sign the application, as well as the applicant or owner and the agent.

# Claims

**Objectives . . .**

In this Unit we will learn the basic definition and structure of a Life Insurance claim. The payment of a claim is the fulfillment of the "promise to pay", the end result of the insurance process that you've studied in previous Units. We will cover the importance a beneficiary, proof of death, and the responsibilities of the insurance company are upon the payment of a Life Insurance claim.

There are four important elements of **Life Insurance claims**:

o) Death Claims
p) Payment of Claims
q) Payments of Claims at Less Than Face Amount
r) Responsibilities of the Agent

## LIFE INSURANCE CLAIMS

With Life Insurance, the payment of a **claim** means the insured has died, and the beneficiary named in the policy will receive the death

benefit proceeds. It is important to note that these claims are rarely negotiated; the claim is either paid or denied. Upon delivery of the claim form and proof of death to the insurance company, the policy is checked for coverage, timelines etc. When the insurance company has established these, the beneficiary is paid the proceeds under the policy.

## PAYMENT OF CLAIMS

The insurance company should be notified immediately upon the death of the insured. Once the proper claim form and supporting paperwork has been received, such as *a death certificate or autopsy report* from a coroner, the insurance company usually does not delay in paying the **claim**. The company will verify that the policy was in force at the time of death, the rightful beneficiary is named, and that there is no evidence of suicide or foul play within the claim. When has been completed, the insurance company usually pays the **claim** within a matter of days. This is a valuable service provided by insurance companies: it is why people buy Life Insurance, and the speedy payment of the **claim** is the right thing to do. Legally, insurance companies have 60 days to pay the claim.

## PAYMENTS AT LESS THAN FACE AMOUNT

There are three situations where a Life Insurance claim might be paid out at less than the face value of the original policy.

First, if there were a **loan against the policy**, the outstanding loan principal and interest would be deducted from the amount by the insurance company. The remainder would be promptly paid to the beneficiary.

Secondly, if the insured dies when the policy is **in the Grace Period**, the amount of the past due premium would be deducted from the face value of the Life Insurance policy before payment is made to the beneficiary.

Thirdly, the benefit payout could be lessened if any discrepancy in the age of the insured is discovered. Protected by the Misstatement of Age or Gender clause when this occurs, the insurance company would determine exactly how much coverage would have been purchased by the premiums paid, and that amount, whether higher or lower than stated in the policy, would be paid to the beneficiary.

## RESPONSIBILITIES OF THE AGENT

The agent, after being made aware the insured's death, notifies the company immediately. The agent may then contact the beneficiary or the beneficiary's legal representative. The Agent may assist, but the beneficiary must complete and sign the death claim, and submit it along with the proof, a certified death certificate, to the insurance company.

***END SECTION***

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

√ **Search this section using CTRL+F**
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# Section LO 5

# GROUP & BUSINESS LIFE INSURANCE

**Objectives**

In this Unit we will discuss **Group Life Insurance**, the life insurance one would obtain at work, or as a member of another eligible group. The different types of **Group Life Insurance** Policies will be examined, as well as probationary periods and the role of dependents in **Group Life Insurance Policies**. There will also be a comparison of **Group Life** versus **Individual Life.**

## Group Life Insurance

**Group Life Insurance** covers many individuals under a **Master Policy**. To be eligible for coverage, individuals must be a member of a specific group whose existence is for other purposes than to obtain insurance. ***Types of policies*** range from group term life, to group universal life and variable group universal life.

Typically, there are four types of ***eligible groups*** that may obtain Group Life Insurance:

s) Individual Employer Groups
t) Members of Labor Organizations
u) Debtor/Creditor Groups
v) Multiple Employer Trusts

**Individual Employer Groups** would consist of the eligible employees of an employer. This is probably the most familiar type of Group Life Insurance. This type of policy normally requires ***at least 10 employees*** to be eligible.

**Employer Responsibilities**

In most group life scenarios, the employer has the responsibility to:

- ***Selection coverage*** for the group
- Assure that no class of employees has been ***discriminated against***
- ***Keep records of enrollment***, coverage periods, premiums, etc
- ***Enrollment*** of eligible employees

**Members of Labor Organizations**, such as the Teamsters and the United Auto Workers, would be organizations whose members would be eligible for **Group Life Insurance**. Remember these groups exist for purposes other than just obtaining insurance. These groups typically require ***at least 25 members*** to be eligible.

**Debtor/Creditor Groups** consist of people who have joined together to pay off a debt to a creditor. This creditor is usually a lending institution. With this type of policy, the coverage reduces as the balance of the loan decreases. The creditor is the beneficiary in this

situation. These groups must have at least 100 new debtors each year. This coverage is written as *decreasing term insurance* and used to pay off the balance of a loan should the creditor die before paying back the loan.

**Multiple Employer Trusts (MET)** are groups formed when the employees of several different eligible employers form a trust fund that combines their numbers for Group Life Insurance eligibility. The number of eligible members can range anywhere *from 100 to 600 members.*

A ***life insurance policy*** is issued to one individual, In Group Life Insurance, **a Master Contract is issued** to the employer (or other appointed designee, as with the other types of eligible groups) who signs it and keeps it. Eligible employees or members complete an enrollment card, providing the necessary information to the employer and are issued a ***Certificate of Insurance.*** The ***individuals covered under the Group Life policy name a beneficiary, usually the spouse or other dependent***. Most Group Life Insurance policies are renewable one-year contracts. The policies must be renewed each year, however, the premiums for Group Life may go up or down as they are based on ***the average age*** *of all the members of the group.*

## CERIFICATE OF INSURANCE

Once a Group Policy is issued by an insurance company, the employer or other appointed designee holds the master policy. A ***Certificate of Insurance*** showing the eligible individual is covered under the Group Life Insurance plan, is provided to each member. The *certificate of*

*insurance* states the dollar amount of the life insurance and the name of the beneficiary.

## BLANKET LIFE

Any life insurer may issue policies of blanket life insurance for a term not exceeding one year with premium rates less than the usual rates for such insurance. Such policies may thereafter be renewed.

Blanket life insurance is written under a policy issued to a newspaper, farm paper, magazine, or other publication and insuring independent contractors, such as newspaperboys, dealers, distributors, wholesalers, or other personnel, engaged in the sale, distribution, collecting for, or other activities pertaining to the marketing and delivery of publications. This includes attending coaching school or while participating in a trip organized, supervised, and sponsored as a reward for meritorious service. Amounts of insurance are based upon a plan precluding individual selection:

- For the benefit of persons other than the policyholder
- Where the premium is remitted by the policyholder;
- Insuring persons without any requirement ***(medical examinations)*** for individual enrollment and with either the policyholder or the insured to pay all or part of the premium

**Group Life In A Qualified Plan?**

In certain circumstances, group life can be purchased for a qualified plan. The idea is that if the employee dies early, there will be a pot of money to help complete his retirement plan. Critics believe the tax deferred accumulation inside a pension plan is wasted.

## CONTRIBUTORY AND NON-CONTRIBUTORY

A **contributory plan** requires that the insured pay part of the premium. The insurance company will usually require that **75% of eligible members participate** in order to avoid the negative effects of adverse selection. There is usually an ***eligibility period*** of 30 days (after the employee's ***probationary period)*** when they may apply for coverage**.**

A **noncontributory plan** is one in which the employer or appointed designee pays the entire premium. It is important to note that the employer establishes these eligibility requirements. For instance, **noncontributory plans** might only be offered to those who have worked for the company for a designated period of time or those who have reached executive or management status. However, if the employer or group makes no special requirements for **noncontributory** eligibility, than all full-time employees who are actively employed and have served any required *probationary periods* would be eligible. This *probationary period* is usually 90 days.

## GROUP LIFE VERSUS INDIVIDUAL LIFE

There are several differences between a Group Life Insurance Policy and an Individual Life Insurance Policy.

**Group policies** cover many individuals under one master policy. An individual policy covers one person.  Buying in a group lowers the insurance company's operating expenses, lowering the premiums. Another difference is that group policies are offered without the

insured having to undergo a ***medical examination*** or provide proof of insurability. And, as you just read, group policies have the advantage of contributory and noncontributory options. Either way, the insured does not bear the full premium as they would under an individual policy.

## CONVERSION PRIVILEGE

When an employee leaves a job or other eligible group they have the right to convert their group term life policy to an individual permanent plan. This conversion period is usually one month. The departing member is  not required to show proof of insurability or undergo a physical examination, since they were already covered under the group policy. The new premium would be higher under a permanent plan.

## GROUP LIFE  AND DEPENDENTS

Group Life plans usually allow for the **spouses of eligible members** to be included under the plan. The same participation percentages apply to dependents and spouses as would under *a contributory or noncontributory plan*. Spouses and dependents are also have a conversion option should the insured die while employed. The amount of coverage would not be the same for a spouse or a dependent however as it would be for an employee or eligible group member. The **maximum coverage is $2,000 per dependent** or the employee would incur tax consequences for any coverage over this amount.

**Allowable benefit levels** – some group plans offer members additional coverage (for a fee).  This allows insureds to add coverage to meet their individual needs.

**Domestic Partnerships --** more employers are offering group plan benefits that provide coverage to the unmarried, unrelated and non-traditional (other than man/woman) employees and their domestic partners. Rules that govern this area are not uniform. In some cases, the employee might need to demonstrate that his or her partner is "eligible" which may be defined as:

- At least 18 years of age
- Not related
- In a committed relationship
- In an exclusive relationship
- Financially interdependent

## EXCLUSIONS

A Group Policy could exclude coverage for deaths relating to:

- War or act of war
- Military or naval service
- Aviation

## INCONTESTABILITY

After a group life insurance policy has been in force for **2** years, it cannot be cancelled throughout the lifetime of the insured, except in cases of failure to pay premiums.

## Misstatement of Age

When a claim is being settled, if the insurance company discovers that the insured misstated their age when they applied for the group policy, the company has the right to adjust the premiums or benefits to properly reflect the insured's true age. This could result in either the insurance company or the insured receiving a credit. **Misstatement of**

**Age** is not necessarily fraud, as it could be a genuine mistake on the part of the insured.

## TERMINATION OF GROUP LIFE

If a Group Life policy issued in this state is terminated by an employer or by an insurer, Conversion Rights to an individual policy apply to all employees, including those who became totally disabled while insured under the policy. If an insured individual dies during the conversion period of a Group Life policy, the amount of insurance is payable as a claim under the Group policy, regardless if the person had not already applied for the Individual policy or made the first premium.

# Business Life Insurance

**Objectives**

In this Unit we will examine how businesses can benefit from a **Life Insurance** policy. After all, businesses often have the same concerns as individuals, families or groups: protection, stability, and peace of mind in a time of crisis. This is a large market in the Life Insurance industry and is important to study.

The three types of business ownership include:

w) Corporations

x) Partnerships

y) Sole proprietorships

**Corporations** are chartered in the state in which they are incorporated and exist separately and legally from the owners of the **corporations**. The owners and the business are actually separate, legal entities. A **corporation** can be *close*: owned by one or maybe a few stockholders who are active within the business. A **corporation** can also be *publicly held*: that is, owned by many stockholders who do not actively participate in the daily management of the company.

## DISPOSITION

Businesses of all types use Life Insurance to handle the disposition of an interest in a business when a sole proprietor, partner or major stockholder dies. The concept of **disposition** is quite important. It may include:

- The selling of the business to a partner or stockholder
- Liquidating the business if it is no longer practical to keep it going

- Keeping the interest within the family that owns the interest

**Selling the business interest to a partner or stockholder** may be done with a predetermined agreement, called **a buy-sell agreement**, and the provision of funds from a life insurance policy. The beneficiary of a Business Life Insurance policy (by the predetermined plan, the surviving partner or other stockholder) would use the funds made available by the proceeds of a Business Life Insurance policy to fulfill the buy/sell agreement at the time of the death of the insured. There are typically two types of buy/sell agreements:

- **Entity purchase**
- **Cross-purchase**

An entity purchase buy/sell agreement has the partnership or corporation, **the entity, purchase insurance** on each principal of the business. The proceeds from the policy provides the money the entity needs to buy out the deceased's interest in the business.

A cross-purchase buy/sell agreement has the partners, owners or stockholders, buy **individual life insurance policies on the life of each principal** of the business. This will allow each surviving member of the agreement to buy out the deceased's interest with the funds provided by the separate insurance policies.

**PUTTING IT INTO CONTEXT** The MacEnroe Law Firm has ten equal partners and an **entity purchase buy/sell agreement** in place should one of these equal partners die. Therefore, **10** separate policies must exist: one for each of the partners. However, if The MacEnroe Law Firm has ten equal partners and a **cross-purchase buy/sell agreement** in place, then **90** separate policies must exist, as each partner will buy a policy on each of the other nine partners.

## LIQUIDATING THE BUSINESS

**Liquidating** the value of business is a drastic measure and does not really involve Business Insurance. It's usually a sole proprietorship and effected more by an individual Life Insurance policy. **Liquidating** a business usually results in a loss of at least 50% of the business' true value. Therefore, the disposition of the company ends with the death of the owner.

## KEEPING THE BUSINESS IN THE FAMILY

In a family-owned business, it may be important to plan for the business to remain in the family should the owner die. One problem is the necessary amount of cash for a family member to buy the interest of the deceased. **Section 303 of the Internal Revenue Code** allows a corporation to buy enough of it's own stock from the deceased owner's estate to cover funeral costs, taxes and administrative expenses. This is only a partial redemption so the family retains ownership of the business. A **Section 303 stock redemption** can prevent a company from having to liquidate should the owner die. The

remaining value of the business would then pass onto the appropriate family member.

## OTHER BUISNESS INSURANCE CONCEPTS

**Key Employee Insurance** allows businesses to insure themselves against the loss of key executives or employees. After all, these people can be the driving force and major breadwinners for a business, and their loss due to death could result in severe consequences for a business. The company serves as both owner and beneficiary of the policy, while the employee is the insured. A business would purchase a policy on the life of a key employee to ensure it's profitability where policy proceeds help to by cover the cost of replacing the employee, added business overhead and salary continuation for the employee's family.

**Deferred Compensation,** often referred to as 'executive compensation' and is sometimes used to connect a valuable employee more closely to a company. It allows businesses to offer compensation at a predetermined date–usually at the employee's retirement. These plans are usually arranged so the employee does not have to pay taxes on the compensation until they are actually paid. If the valuable employee dies before retirement, then the benefits are paid to a beneficiary, who then must pay taxes on the compensation. If the employee retires, under a **deferred compensation plan**, than the company would make payments to the retired employee, who then would be responsible for the taxes.

In a **Section 457 deferred compensation plan**, certain state and local government employees are eligible to set aside (defer) part of

their earnings. These deferred amounts are not considered part of the employee's gross income until they are actually received. Normally, an employee may not defer more than **25%** of their income. As noted before, this does not include other deferred amounts set aside by the employee. The benefits under a **Section 457** plan are taxed when the benefits are made available to the employee or their beneficiary.

**Split Dollar Insurance** insures the life of an employee and divides the premium payments between the employee and their employer. This allows an employee wanting Life Insurance to obtain it at a lower outlay. The employer's portion of the premiums are usually *equal to the increase in the policy's cash value.* Upon death of the insured, the employer gets that part of the death benefit equal to the cash value of the policy or the premiums paid. The insured's beneficiary receives the balance.

**Executive Bonus Plans** allow companies to provide Life Insurance to selected employees. These plans typically involve a key executive, who purchases a life insurance policy with a named beneficiary other than their employer. The employer agrees to pay the cost of the premiums in the form of a cash bonus to the executive, taxable to the employee and deductible as compensation to the employer. Upon the death of the insured, the proceeds are paid to their beneficiary.

## *END SECTION*

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

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# Section LO 6

# RETIREMENT PLANS

**Objectives**

This unit will discuss the important connections between **retirement plans**, annuities, and life insurance. We will examine the differences between **qualified and nonqualified plans,** and how they can effect the insured's **tax situation**. Brief descriptions of the many different types of **retirement plans** will be given including: IRA's, Pensions, 401K's, SEP's, SIMPLE's, Keogh plans and Annuities.

## QUALIFIED AND NONQUALIFED PLANS

### QUALIFED PLANS

The importance of preparing early for retirement is a major concern to individuals and businesses alike. The federal government has recognized this importance and provides large tax benefits for certain **qualified plans which must meet several IRS requirements** in terms of funding, benefits, participation, and vesting. ***Individuals can only open non-qualified plans (discussed below). Employees, however, through their employers are eligible for Qualified plans. Qualified plans are:***

z) Tax-deductible to the employer

aa) Non-taxable to the employee at the time of contribution

bb) Accumulate on a tax-deferred basis

cc)Taxed at time of payout

In essence, qualified retirement plans provide security and strength to the employee's, as well as lowering both employee and employer income tax liabilities. Examples include traditional 401k and 403b for teachers.

***Non-qualified plans*** are plans started by individual or the self-employed, like IRAs, Keoghs, Simplified Employees Pensions or individual 401k plans. They offer certain deductions of constributions and tax-deferred earnings. Beyond these, there are additional non-qualified plans that employers can establish as well. Contributions made on behalf of the individual employee allow him to defer (up to certain maximums) the amount contributed as income, and defer tax on any interest or profits earned until retirement when tax brackets are expected to be lower. Examples include split dollar life, non-qualified annuities, executive bonus plans and deferred compensation plans.

Within qualified retirement plans there are two distinctions:

- Defined benefit plans
- Defined contribution plans

**Defined benefit plans provide predetermined benefits** to it's participants. A formula is used to determine these predetermined

benefits. The contributions made to these plans are used to fund the plan and benefits. It is important to note that the organization and maintaining qualified retirement plans is a difficult and lengthy undertaking, as there are many complex rules, regulation and requirements concerning how these plans are administered. However, an agent who understands the in's and out's of qualified plans can be successful in selling these plans. Qualified retirement plans relate to life insurance in that many plans may be funded with life insurance products and are sometimes sold by life insurance companies.

***Group Deferred Annuity***- An employer holds the master contract and issues certificates of participation to the employees covered in the plan. Predetermined amounts of deferred annuities are purchased annually to fund an employee's retirement plan. Whatever this monthly amount may be (it could be a percentage of salary or a flat monthly contribution), it is multiplied by the number of years the employee worked before retirement. The resulting amount would be the retiree's monthly retirement payout. For example, if an employee's group deferred annuity monthly contribution is $100 a month, and the employee works 20 years, then they may expect a monthly retirement salary of $2000.

***Individual Deferred Annuity-*** These plans take out individual deferred annuities on each person involved in the plan. The rate is determined on an individual basis, and can be based on age, gender or time of employment. The premiums in individual deferred annuities remain the same until retirement age is reached, unless the employee's salary changes. An increase in the employee's retirement benefits would then be necessary.

Defined Contribution Plans are qualified plans that **are based on the contributions made to the plan, not the amount of benefit**. Examples of defined contribution plans include;

***Profit Sharing Plans***- These are established by employers so employees can share in the profits of the company. The amount of the contribution made by the employer is up to the employer, and the contributions are held in trust. When the participating employee retires or leaves the company for other reasons, the contributions (and the earnings or interest made on them) may be provided to the employee.

***Pension Plans***- These are also established and maintained by employers who wish to offer to retired employees payments over a number of years or for life. Employer contributions are often based on number of years worked or earnings. It is important to note that plan contributions are not based upon the company's profitability or left to the discretion of the employer. There are two major types of pension plans. The first is a **money-purchase** plan, in which the employer makes fixed annual contributions to the plan. These amounts are then allocated among the accounts of plan's participants. Upon retirement, the accrued amounts in the employee accounts can be used to purchase certain benefits in that plan. Secondly, there is a **target benefit** pension plan. It works much like a money-purchase plan in that the system of employer contributions is the same. However, a target benefit is specified and that target may or may not be reached.

***401k Plans***- This is an extremely well known retirement plan in which an employee can defer a certain amount of their earnings to the

qualified plan. A 401k plan usually involves a pre-tax deduction from the employee's paycheck into the plan. The amount of the contribution is chosen by the employee and may be expressed as a percentage of compensation or flat dollar amount up to the maximum allowed by the IRS. The employer may or may not include a matching contribution of a certain percentage.

An **Employee Stock Ownership Plan (ESOP)** may be part of a 401K and/or Profit Sharing Plan, and allows an employee to purchase shares of stock in the company on a pre-tax basis. This amount may be determined by employee compensation or job classification.

## IRA'S AND ANNUITIES

Individual Retirement Accounts and annuities allow for individuals to plan for their own retirements. These plans can be arranged with life insurance companies, banks, credit unions, mutual funds, or other brokerage firms. The dollar amount one contributes to an IRA may be deductible from taxable income. The IRS places monetary limitations on the deduction amount and is based on how the individual files their taxes (single or married filing jointly). The growth on all IRA earnings is deferred until the funds are withdrawn.

The most popular IRA's include:

- Bank trust accounts
- Mutual funds
- Bank accounts or certificates of deposit
- Fixed or variable rate annuities

Other kinds of IRA's include;

***Roth IRA's-*** These differ in that the **contributions are made after taxes.** Earnings in Roth IRA's tax deferred and may be **withdrawn tax-free**. The owner of the plan must be at least 59 1/2 years old and must have held the Roth account for at least five years, or in case of death or disability. A withdrawal can also be made of up to $10,000, for the purchase of a first home. Additionally, the principal is always available without penalty.

**Education IRA's** -- an account created as an incentive to help parents and students save for education expenses. The maximum contribution is $2,000 in any given year. The beneficiary is someone under 18. Contributions are not tax-deductible, but grow tax-free. Distributions are tax free as long as they are used for qualified education expenses such as tuition, books, supplies and qualified room and board.

**Thrift Funds & Accounts** – a voluntary retirement savings plans for civilians who are employed by the U.S. Government. Maximum annual tax-deductible contribution is $20,000 or 1 percent of pay. Funds grow tax-deferred and must be withdrawn like IRA's or rolled over into an IRA Rollover Account.

***SIMPLE plans-*** A Savings Incentive Match Plan for Employees can be established by small **businesses that employ no more than 100 people**. This plan can either be an IRA or 401k plan. Employees may elect to contribute an amount indexed for inflation into a SIMPLE account. Employers can elect to contribute by either **matching the employee's contribution dollar-for-dollar up to 3%, or they may contribute 2% of compensation** to the account of each eligible

employee on an annual basis. All contributions are immediately vested.

***Simplified Employee Pensions-*** SEP's are for the self employed and allow larger contributions than under previously mentioned plans. All eligible employees must be included and the employer contributes according to a pre-determined percentage.

***Keogh Plans-*** These are retirement accounts also for those who are self-employed. Keogh plans also are divided into defined benefit plans and defined contribution plans. Contributions to a Keogh plan are tax deductible as long as they follow certain IRS guidelines.

***Tax Sheltered Annuity Plans (TSA)-*** These are also known as 403(B) plans. It is a **qualified retirement plan for employees of public school systems, hospitals, and non-profit organizations.** The employee allows the employer to withhold part of their salary, which the employer then uses to buy an annuity. The withheld amount is not taxable. Like other plans, the growth is not taxable until withdrawn.

## OTHER CONCEPTS

**Plan distribution** concerns when the funds from any qualified retirement plan can be withdrawn. Generally, these funds may be distributed any time the employee retires, terminates employment or is fired. However, if the individual withdraws funds before the age of 59-1/2 years of age, the IRS imposes a 10% penalty tax. This is in addition to the regular income tax that would be applied to the funds

upon being withdrawn. It is important that individuals be aware of the taxation rules and consequences of early withdrawal or retirement.

**Incidental Limitations** concern the purchase of life insurance with the funds from qualified plans. The IRS has limits that ensure the death benefits of such policies be 'incidental' to the plan's other benefits. In a defined plan, the face value of the plan cannot exceed 100 times the monthly pension benefit.

**Rollover** is a term used when the proceeds from one IRA are transferred into another. This is common when employee's change jobs: they 'rollover' their existing retirement plan funds into a new IRA. Rollovers are allowed once per year per account.

**Vesting** refers to a schedule that an employer establishes to determine what percentage of ownership the employee has in the **employer's contributions** to qualified plans. This schedule must satisfy certain IRS rules about tax qualification. Vesting generally relates to how long an employee has worked for their employer. Any **employee contributions to a plan are immediately vested**.

**Fully funded** means a retirement plan has enough capital, return on investment and other resources to pay all retirement payout claims. If a plan is not fully funded the Pension Benefit Guaranty Corporation will typically insure any shortfall that might occur.

**Non-discrimination rules** – in order for a pension plan to qualify for tax benefits, it must meet federal non-discrimination rules designed to

ensure that benefits of the plan do not disproportionately accrue to highly compensated employees.

**ERISA** means The **Employee Retirement Income Security Act** (1974) and protects the interests of employee **participants and the beneficiaries of retirement and benefit plans**. The law makes certain that whomever controls the funds and management of a plan must act solely in the interests of the participants. Any and all information must be disclosed to the participants, the IRS, and the Department of Labor.

***END SECTION***

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

√ **Search this section using CTRL+F**
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# Section LO 7

# TAXATION & LEGAL ASPECTS OF LIFE INSURANCE

## Life Insurance and Taxation

**Objectives**

In this Unit we will cover the very important aspects of **taxes** as they apply to **Life Insurance**. This is an area that your customers will have many questions and concerns about. So, we will examine how taxation effects both **Individual and Group Life Insurance**, as well as the importance of a *Modified Endowment Contract (MEC).* You will study and become familiar with some of the advantages and the qualifications for these **tax advantages**. Finally, we will cover such topics as charitable donations of **Life Insurance** and the **taxation concerns** of Business Insurance.

## TAXATION AND INDIVIDUAL LIFE INSURANCE

Life Insurance policies have **two distinct tax advantages**. The first is the fact that the **yearly build up of cash values of the policies are tax deferred;** that is, until they are distributed. Secondly, ***death benefits*** **proceeds of a policy payable to a named beneficiary at the insured's death are generally income tax free to the**

**beneficiary**. These tax advantages have caused many to purchase life insurance policies not just for their traditional uses, but also as a savings or accumulation resource.

In recent years, **the IRS has established a definition of life insurance** and policies must meet the requirements of at least one of the following tests:

**Cash Value Accumulation Test-** the cash surrender value of the policy should never exceed the net single premium that would be necessary to fund future benefits.

**Guideline Premium and Corridor Test-** This relates to the actual amount of real insurance in the policy. Simply put , it is the relationship between the cash value of the policy and the amount of the death benefit. This cash value must not exceed a certain percentage of the total death benefit.

If a policy does not pass at least one of these tests it will **fail to qualify** as Life Insurance. This possibility could have serious **tax consequences** for the insured. The earnings of the policy could become taxable. Also, the beneficiary may not receive death benefit tax-free.

## MODIFIED ENDOWMENT CONTRACT

If a Life Insurance policy becomes a **MEC** (covered in an earlier Unit), it also has serious **tax consequences**. Money distributed from a MEC is considered to come first from earnings–the excess of the cash value over the policy's cost basis–and is taxed as ordinary income.

## PREMIUMS

Generally, **life insurance premiums are not tax deductible**.

## ACCELERATED BENEFITS

Accelerated benefits are considered an **advance on the death benefit**, and may be received **tax-free** as long as they are qualified. In this sense, qualified means that the insured is terminally ill, and expected to die within 1-2 years of the date on which the accelerated benefit is paid, or the money is used to pay for their long-term care do to a chronic illness. The ***insured may take accelerated death benefits in a lump sum*** or choose the option to receive periodic payments.

## DIVIDENDS AND SURRENDER VALUES

The policy dividends that are paid to the insured are not taxable, as they are considered by the IRS to be a partial return of the premiums, but any **interest earned on those dividends is taxable.**

When money is received from a ***surrendered life insurance policy*** or ***matured endowment***, the gain (if any) that exceed the premiums paid (cost basis) for the policy, is taxable as ordinary income. For example, if one surrendered a life insurance policy with a cash value of $50,000, and had paid $37,000 in premiums during the time they had the policy, the taxable gain would be $13,000.

## ANNUITY PAYMENTS

Income received from annuity payments, like any other settlement option, is subject to limited income taxation. The IRS determines how much of the annuity is a 'return of capital' (therefore not taxable) and

taxes the remainder of the annuity income payment. Once the cost basis has been received by the insured, then all annuity payments become taxable.

## GROUP LIFE INSURANCE

When received in a lump sum payment, the proceeds paid from a Group Life Insurance policy are not taxable. The premiums towards a Group Life Insurance policy is not tax deductible to the employee, However, the employer can deduct these premium payments as a business expense.

## OTHER CONCEPTS

### CHARITABLE GIVING OF LIFE INSURANCE

There are two ways to give life insurance as a charitable gift. The first way is by making an outright **gift of the policy** on the life of the donor. The charity would be the owner and beneficiary, and the donor may deduct the value of the policy at the time it is given as a gift. The charity must receive all rights of ownership in the policy. If this is not the case, the tax deductions would be lost. The second way to make a charitable gift of life insurance is for the donor to make the charity the beneficiary while paying the premiums on the policy. The donor, in this case, retains ownership of the policy. Thus, the premium payments are not tax deductible, but **the total amount paid at the death of the insured is an estate tax deduction**.

### LIFE INSURANCE AS A GIFT

The most common way of giving a Life Insurance is to give Life Insurance as a gift is to make a gift of the premium payments. A 'gift tax ' ($10,000 for a single donor or $20,000 annually for a gift by a

donor and spouse, indexed for inflation) may be levied by the IRS if the dollar amount of gifts given annually exceed these amounts. The individual receiving the gift does not have to pay any tax.

## SECTION 1035 –POLICY EXCHANGES

Since insurance and annuities are considered assets as well as property, gains incurred can be considered by the IRS for tax purposes. However, Section 1035 of the IRS Code provides that no gains or losses are recognized in certain situations:

dd)

ee) The exchange of a life insurance policy for another, or for an annuity or endowment

ff) The exchange of an endowment contract for another or for an annuity

gg) The exchange of an annuity for another

Any exchanges outside the above examples are considered taxable by the IRS.

# Legal and Professional Aspects of Life Insurance

**Objectives**

After carefully studying this Unit, you will be familiar with the many **Legal and Professional considerations in Life Insurance**. These will be important in your career as a licensed insurance agent. Some of the topics you'll cover here are regulatory issues, the **testing and licensing of agents** (this section just might read a little familiar to you!) and **ethical considerations** in the industry.

## INSURANCE LAWS

### THE COMMISSIONER'S OFFICE

Governmental agencies regulate the insurance industry. The industry is considered a public trust because it performs a public service by providing insurance. The large amounts of money involved with insurance are another reason why the industry is subject to regulation. This regulation is largely left up to the individual states. Each state appoints an Insurance Commissioner and a department that regulates the insurance industry within the state. These state insurance regulatory departments are then responsible for establishing the requirements that insurance companies must follow to sell insurance. The Commissioner decides which companies are allowed to do business in the state (see Unit 19). The Commissioner also requires that insurance companies are financially sound and able to live up to the promises of the issued policies. Every five years, inspections are made to insure insurance companies are operating responsibly. If an

insurance company is found to be operating in an unsound manner, the Commissioner has the right to revoke their license. As you can see, this is quite an important and powerful department. This department also investigates and responds to complaints received from insurance consumers.

### NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Including Washington, D.C., this organization includes the 51 insurance commissioners within the United States. The NAIC makes recommendations to provide a certain amount of uniformity in how the insurance industry in regulated in each state.

## EXAMINATION AND LICENSING OF AGENTS

As you will know, each state requires every prospective insurance agent to first pass an examination that covers the substantial amount of information you will need to be familiar with. There is a test for receiving a life insurance license as well as a health insurance license. The renewal of this license, once granted, varies from state to state. Selling insurance without a state-issued license is not an option: there are stiff fines and possible prison sentences for fraud.

Once the written examination is passed and the license received, the agent must be appointed with an insurance company. The ***notice of appointment*** is filed with the DOI and states that the agent is authorized to transact insurance on behalf of the insurance company..

It is important to note that one can be a resident agent or a nonresident agent. A resident agent lives and sells insurance in the same state. A nonresident agent does not live in a state, but is

licensed to sell insurance there. Most states now have reciprocal agreements that provide a licensed agent who lives in one state can sell insurance in another state by applying for a nonresident license.

# AGENTS, COMMISSIONS AND ETHICS

## AGENTS

Once one becomes a licensed agent, there are certain **powers of agency** stated in the agreement between the agent and the insurance company:

hh) Expressed authority
ii) Implied authority
jj) Apparent authority

Expressed powers are clearly **stated in the agreement** between the insurance company and the agent, as well as in the underwriting policies for the company.

**Implied powers** are the things an agent is expected or known to do, and are **implied in the agreement** between the company and the agent.

**Apparent powers** are when are agents do something for which they seem to have authority such as advertising a companies products for sale. Courts of law have held this concept to be legal. An agent who misrepresents a company with apparent authority may be held liable for that mistake, including payments made to the insured when an agent makes the company bound to a risk.

Note that there is a legal difference between the term *'agent'* and the term *'broker'*. An **agent represents an insurance company** a **broker represents clients** and may sell for several companies.

## COMMISSIONS

A commission is the payment an agent receives for selling insurance policies. Any licensed and appointed agent can receive a commission.

**Commission Splitting-** This refers to a commission that is split between two or more agents. This typically occurs when a new, inexperienced agent asks for the help of an experienced agent in closing a sale with a customer. If both agents are licensed for that line of business, it is permissible to split the commission.

## ETHICS

The following concepts will be very important to the success and longevity of your future career as a life insurance agent. The insurance industry has its own particular set of ethical expectations and concepts, most of which involve a good deal of common sense. It is important that you know them.

**Rebating-** This practice refers to an agent giving a potential customer a kickback for buying a policy. It is punishable by loss of license. No other inducement, other than what is offered in the policy itself, should be offered to a customer to secure the sale of a policy.

**Twisting-** Twisting involves an agent contacting a policyowner with an existing policy and convincing them to lapse or surrender that existing policy. The agent, usually from a different company, then tries to sell the person another policy. Twisting is harmful to the insured

because they may lose the accrued cash value on their existing policy by letting it lapse or giving it up. They may also lose the lower premium payment associated with an older policy as well as a more favorable rating classification.

It is important to note that not all policy replacements are illegal. Sometimes it can be beneficial to the insured. Specific steps must be taken by the agent to have a policy replaced. The agent must demonstrate to the insured that better policies and protections are needed.

**Churning-** Similar to twisting, the agent uses misrepresentation to convince an existing policyowner of the agent's own company, as opposed to a competing company. Churning allows an agent to receive a new commission on a new policy. The customer's interests should be placed ahead of the agent's.

**Misrepresentation-** The population at large is mostly unfamiliar with how life insurance actually works. This is where the agent comes in. They must be knowledgeable about the products they are selling, and be capable of correctly and fully explaining a policy to a customer. The agent must also be very familiar with how their company does business. Anything outside of a complete and full knowledge of these topics could be interpreted as misrepresentation and result in an agent's license being revoked.

**Fraud-** An license can be revoked by the Insurance Commissioner's Office for any fraudulent misrepresentation or dishonest effort to defraud an individual or company.

**Failure to Remit Premiums-** When policyowner's make a premium payment to an agent, they assume their money and their policy is in good order. It is the agent's responsibility to deliver those premium payments to the insurance company. Any agent who withholds premium payments for an unreasonable amount of time could face revocation of their license and other legal actions.

**Need For Errors and Omissions Liability-** A mistake by an agent can be costly to everyone involved: the insured, the company, and the agent himself who can be held legally liable. It is very important that agents be familiar with the products they sell, be able to explain policy coverage to customers, and be able to accurately and completely fill out all applications and paperwork involved with a policy. The three most important areas for an agent to cover are:

kk) Making sure the insured obtains the correct coverage
ll) Making sure the insured obtains adequate and sufficient coverage
mm) Making sure the insured's coverage is maintained

Even when an agent is extending his best efforts, mistakes happen. That is why E&O insurance is necessary. It protects the agent and the client. Most policies are written as ***claims made*** (covering claims made within the policy period) ***Occurrence-based*** E&O covers claims when they are made . . . perhaps even after an agent has retired. It is important to note that errors and omissions insurance

**IMPORTANT E&O COVERAGE GAP**: If you purchase E&O insurance it will likely cover you for mistakes, advertising goofs and the like. But, E&O rarely covers negligence. In essence, you can't just do or say anything you want and expect your E&O to cover.

While the purchase of professional liability, errors and omissions insurance, can cover exposure to this occurrence, it is best for an agent to be proactive and reduce exposure to these risks by:

- Placing your customer's interest first. Selling only products with the highest commission is not putting your customer first.
- Know your job and increase your level of competence. Just doing the minimum is not enough.
- Identify the customer's needs and recommend products and services that meet those needs. If your client is young, on a budget, with a mortgage and college bound kids, perhaps a whole life policy does not provide enough protection compared to a term life plan.
- Accurately and truthfully represent products and services. An annuity with a large withdrawal penalty might not suit an old lady with liquidity needs.
- Using simple and clear language with customers and companies. This is just common sense. People need to understand what they are buying.
- Stay in touch with customers and conduct period coverage reviews. This is part of customer service that gets you good yelp ratings and referrals.
- Protect your confidential relationship with your client. Anything else is unethical.
- Keep informed and obey all insurance laws and regulations. Forgetting to print your license number on a business card seems small, but it could get your license suspended.
- Provide exemplary service to your clients. Wow them. Do more than they expect to get their continued business and referrals.

- Avoid unfair remarks about the competition.  It's unprofessional and could land you in court with a defamation case.
- Being familiar with their company's procedures, operations and standards
- Asking for help from experienced agents

## *End of Section*

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section.  Re-Take Quiz as needed.***

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# Section LO 8

# INSURANCE COMPANIES, THE COMMISSIONER AND LICENSING

## Life Insurance Companies

**Objectives**

This Unit will cover information you should know about **Life Insurance Companies** and how they are organized. This Unit will also give you the required information you'll need to answer the questions on the **state licensing exam**, as well as give you some information about future employers.

The basic types of **Life Insurance** companies include:

- Stock companies
- Mutual companies
- Fraternal companies

### STOCK COMPANIES

Any corporation that sells shares of ownership (known as shares of stock) of the company is known as a stock company, and may pay

dividends to the **stockholders**. A company that sells insurance of any kind may be organized as a stock company.

**Dividends & Earnings?**

In a mutual insurance company, all surplus belongs to policyholders. In a stock insurance company, however, stockholders get most of the dividends. Fraternal companies may also pay dividends to participating policyholders or issue paid-up insurance certificates. A participating policyholder could earn an equitable portion of a Company's earnings (divisible surplus) in the form of policy dividends. Earned surplus is the sum of a company's profits, after dividends, since inception.

### MUTUAL COMPANIES

Some of the oldest Life insurance companies were organized as mutual companies and are owned by policyholders. Policyholders with these companies are considered to have ownership of the company (the 'mutual' interest) and may be paid dividends on their policies.

### FRATERNAL INSURANCE COMPANIES

Insurance underwritten by a fraternal society formed to provide benefits (mutual aid, insurance, etc.) for its members. Examples, include Knights of Columbus, Modern Woodmen of America, Odd Fellows, etc.

## DOMESTIC, FOREIGN AND ALIEN COMPANIES

You may want to get out a notepad and a pen for this section. The distinctions between **Domestic, Foreign and Alien companies** are very important and will be covered on your licensing exam. It will also be important for you to know these distinctions during your career as

an agent. You will also read about insurance companies that are **Authorized or Unauthorized** to sell insurance within a state.

## DOMESTIC COMPANY

Companies organized, incorporated and chartered under the state regulations where it's home office is located are referred to as a Domestic Company. **A company incorporated in California would be a Domestic Company**.

## FOREIGN COMPANY

A **Foreign Company** would be a company that is organized and **chartered in another state** from which it is doing business. For instance, when the same company that is chartered in California does business in any other state, it would be referred to as a **Foreign Company**. The same would be true for a company chartered in another state doing business in California.

## ALIEN COMPANY

Companies that are domiciled in countries other than the United States are called **Alien Companies**.

## AUTHORIZED COMPANY

It is up to the Insurance Commissioner of each to state to determine if a life insurance company is authorized to sell insurance within that state. The Insurance Commissioner will conduct a thorough investigation to see if a life insurance company can be authorized to sell insurance. The Commissioner looks at such factors as the company's financial health, the nature of the policies the company will offer, and the type of advertising the company will use.

**UNAUTHORIZED COMPANY**

If an insurance company does not meet the Insurance Commissioner's requirements, that company is denied permission to sell insurance in that state and is known as an unauthorized company. Agents cannot sell polices for insurance companies that are unauthorized to sell in a state.

## OTHER COMPANIES

The following is a brief description of other organizations that offer different types of Life Insurance policies.

***Reciprocals-*** These kinds of companies have participants who agree to share the responsibilities and losses with all the other members of a reciprocal. A reciprocal is unincorporated. Simply, the participants insure one another as well as share the losses of the reciprocal. An attorney-in-fact manages these organizations.

***Surplus Lines-*** These organizations may come into play when an individual is considered uninsurable by an authorized insurance company. This may be because of the person's occupation, health, or dangerous hobby. States have different laws as to what companies can sell surplus lines and be known as a surplus lines broker.

***Lloyd's-*** Lloyd's is a voluntary insurance organization of individuals or associations of individuals, a syndicate, who agree to share in certain insurance contracts.

***Rating Organizations-*** While not an insurance company, rating organizations are important to the health and vitality of the insurance industry. These companies track and rate insurance companies based on important statistics, such as financial history. A well known rating company is the A.M. Best Company, which publishes a ratings guide. This can be an important resource for insurance agents and consumers alike. They assign a rating to the operations and financial condition of insurance companies, an 'A+ - Superior' through 'D - Poor' grade, as well as comments about the financial and regulatory conditions.

## MAJOR FUNCTIONS & DEPARTMENTS OF INSURERS

Insurers divide their company in major departments organized by function and include;

- ***Actuarial***; responsible for data analysis, loss predictions, mortality and morbidity, premium determination
- ***Underwriting***; determines standards for risks, evaluates applicant information, approve, decline, and rate risks
- ***Claims***; investigation and settlement of claims
- Administration; policy issue, billings, commissions
- Investments; responsible for investment return for the insurer
- ***Marketing; sales***, advertising, promotion and recruiting, training agents

# The Commissioner & Insurers

## Objectives

In this unit we will discuss the office of **Commissioner of the California Department of Insurance (DOI)**. Another section of the Unit will describe the different types and classifications of Insurance Companies.

### 1. General Duties and Powers

The **Commissioner of the California Department of Insurance (DOI)** is the ***elected official*** responsible for administering and enforcing the laws of the California Insurance Code, and the California Code of Regulations.

Currently, the Commissioner has a **14** member executive team that includes a Chief Deputy Commissioner, General Counsel, Chief Deputy of Operations, and Deputy Commissioners for Enforcement, Financial Surveillance, Rate Regulation, Consumer Services and Market Conduct, Legislative, Community Relations, Communications and Press Relations, as well as several assistants. Together they oversee 1350 employees, a $200 million budget, and nine bureaus made up of Auto Enforcement, Sacrament Enforcement, San Francisco Enforcement, Corporate Affairs I and II, Policy Approval, Rate Enforcement, Fraud Liaison, and Government Law.

Note: In some states this office is referred to as the **Director** or the **Superintendent of Insurance**.

The **Commissioner** is responsible for enforcing the ***California Insurance Code (CIC)***, which are laws passed by the state legislature and the ***California Code of Regulations (CCR)***, and also the administrative law written by the **Commissioner** and staff to further interpret, explain, and enforce Code. Both the CIC and CCR are subject to change by a process described below.

***The California Code of Regulations (CCR)***, under Title 10, Chapter 5 of the CIC, is composed of rules that are issued by the insurance commissioner. The commissioner is authorized to issue these rules. However, the Office of Administrative Law must approve the rules before they can become effective. These rules or regulations are not law, but carry the same weight as law and a person who violates any of the CCR is subject to the same penalties as someone who violates a statute.

It is important to note that the **Commissioner** may *not* make changes to the Insurance Code. Only the state legislature may make those changes. However, the **Commissioner** *may* review the Insurance Code and issue recommendations for changes.

### A. Issuing Orders

The Commissioner can issue orders, which are oral or written actions given to an insurance company, any representative of an insurance company, or anyone outside the DOI. An official order must include its intent, its effective date, the information the order is based on, and the specific Insurance Code provision that directly relates to the order.

A **Cease and Desist Order** is a written order from the Commissioner that tells someone they need to stop what they're doing. If the Commissioner determines that a Producer is doing something illegal or dishonest, the Cease and Desist Order means "knock it off or else…"

The Commissioner can issue a Cease and Desist Order to an authorized individual who is:

- Transacting insurance without the proper authorization
- Involved in dishonest or unfair acts
- In a hazardous condition
- In a hazardous financial condition
- Dangerous to the safety of the general public

Note: "Hazardous condition" is a legal term meaning the insurer/company is doing something construed as shifty. This could be filing a falsified financial report, not filing a financial report when its due, or claiming it has more/less money than it really does.

A **Cease and Desist Order** has to contain:

- The name and last known address of the person/organization
- A statement regarding the violations, and which parts of the code or which regulations were specifically violated
- The danger the violations could pose to the public
- The proposed penalty
- A command for the person/organization to immediately stop violating the code

## B. Hearings

The Commissioner has the power to hold hearings. These hearings must be held upon written demand to the Commissioner. The written demand must include the reason for the Hearing. During the hearing, the Commissioner may:

nn) Deliver oaths and affirmations, subpoena witnesses and examine under oath any person who may be able to offer information towards the investigation

oo) Require the individual being investigated to produce any relevant evidence

The Commissioner may appoint examiners, administrators or deputies in order to collect evidence or conduct hearings. The Commissioner is responsible for the actions of these appointees and may revoke these appointments at any time. The Commissioner may act under the Insurance Code in a quasi-judicial capacity, in that the Commissioner may apply to any judge of any county circuit court for court-ordered contempt orders.

## C. Issuing Penalties

The Commissioner can issue **3** different types of penalties towards those in the insurance industry:

1) Civil Penalties
2) Criminal Penalties
3) Disciplinary actions towards applicants or licensed agents

Here's a closer look at those **3** types of penalties:

**Civil Penalties** can be imposed on any insurance company that violates any provision of the Insurance Code. These penalties could be as high as:

- **$1,000** per violation for individuals
- **$10,000** per violation for companies

A Civil Penalty must be paid within **10** days after the order becomes final.

The Commissioner will impose **criminal penalties** if a violation of the Insurance Code leads to a criminal conviction for an individual. These penalties could be as high as:

- Up to **1** year in county jail, or a maximum fine of **$1,000** for individuals
- A maximum fine of **$10,000** for companies

**Disciplinary actions** towards applicants or licensed agents are actions the Commissioner may take against any licensed individuals or applicants for license. The Commissioner may revoke, suspend or refuse to renew a license for any business or classification of insurance. Also, the Commissioner may refuse to issue a license or grant authority for license to transact or engage in any business or class of insurance.

The following is a list of violations the Commissioner may penalize for:

- Incompetence or untrustworthiness of an agent
- Any dishonest or deliberately false act in relation to the insurance application or examination

- Violation or noncompliance with the Insurance Code
- Misappropriation, embezzlement or any illegal withholding of customer monies
- Conviction of any felony or imprisonment
- Material misrepresentation of policy terms
- Fraudulent or dishonest practices in transacting insurance business
- Failure to pay a civil penalty, fee, or charge assessed by the Commissioner
- Improper or illegal use of an insurance license
- Cancellation, revocation, suspension or refusal to renew the license by any other state or government agency
- Failure to comply with Continuing Education requirements
- Evidence of dishonesty, fraud, or misrepresentation of an agent even if such activity is not related to the insurance business

## D. Financial Statements and Investments

All California insurers are required to submit a financial report to the Commissioner by December 31st **and due by June 30th**. This annual report includes information on the company's/insurer's:

- Capital
- Stock
- Assets
- Liabilities
- Income
- Expenditures
- Balance sheet

- All insurance and premiums written in California.

Note: Audits determine the insurance company's financial condition, nature of operation, ability to fulfill insurance obligations and the presence of any Insurance Code violations. The insurance company under examination pays for any costs associated with these audits. The report becomes a public record.

## 2. National Association of Insurance Commissioners (NAIC)

The **NAIC** is an organization formed by the **Insurance Commissioners** from all **50** states, Washington, D.C., and Puerto Rico.

The purpose of the NAIC is to promote and support uniformity between the states in regards to the insurance business. The NAIC keeps a registry of all agent and producer licenses granted in each state that require such licenses.

Note:
With respect to the NAIC, insurance “agents” are now known as “producers,” unless you’re in a state where they’re still known as “agents.” In California, we call them producers, but if you think of the two as synonymous, you’ll do just fine.

This registry lists both licenses and appointments by state. The NAIC has formed a 'model bill' for each state to present to their state legislatures when attempting to make changes to State Insurance Code.

## 3. Classification of Insurance Companies

In California, **any person** capable of making a contract **may be an insurer**, subject to the restrictions imposed by this code. A “person” "Person" means any individual, association, organization, partnership, business trust, limited liability company, or corporation.

There are **3** different types of insurance companies for classification purposes:

1) Domestic
2) Foreign
3) Alien

Here's a closer look at those **3** classifications:

**A. Domestic**

Domestic insurance companies are ones that are incorporated and domiciled in California.

**B. Foreign**

Foreign companies are ones formed under the laws of any other state in the U.S.

**C. Alien**

Alien companies are formed and originate in another country outside of the U.S.

Alert!
Some of the final exam questions are danged hard…and some are a relaxed stroll through the park on a lovely summer's day. An example of the latter is that there are a number of questions about the **3** categories of insurers. Memorize the **3** categories of insurers, which should take you all of five seconds.

No matter the classification, all insurance companies in California must have a **certificate of authority**, which is issued by the Commissioner.

An **Admitted Insurer** has a certificate of authority and is permitted to do business and appoint agents in the state of California.

All authorized insurance companies have to:

- File detailed annual financial reports
- Pay all fees and expenses of the DOI examiners
- Contribute to appropriate insurance guaranty funds
- Agree to abide by all insurance Laws and Regulations
- Produce insurance business through licensed producers/agents

Note: If someone violates the requirement for a ***certificate of authority***, they could face penalties of:

- Imprisonment in state prison, or in a county jail for up to **1** year
- A fine of up to **$100,000**
- All of the above

An **Nonadmitted Insurer** is one that does not have a certificate of authority and is not permitted to appoint agents in the state of California. Unless a surplus lines broker is specially licensed to represent unauthorized insurers, ***an agent is prohibited from acting as an agent for a nonadmitted insurer in the transaction of insurance; advertising a nonadmitted insurer and/or aiding a nonadmitted insurer to transact business in the State.***

***Putting the use of "nonadmitted" insurers into Context:***

A consumer may need more unique insurance than what is available from traditional, admitted carriers, i.e., he may need the help of a surplus line broker representing a non-admitted carrier. Surplus Lines

brokers handle insurance for very high risks . . . a legitimate and valuable service. For example, if someone wanted to insure a shipment of volatile chemicals, it would be difficult for them to insure such a high risk through the normal insurance market.

However, until the passage of the Dodd-Frank Wall Street Reform Act (2010), the regulation of surplus lines brokers was minimal AND, the potential consequences for consumers high, witness the recent failure of many small, nonadmitted bond insurers. Thus, as an agent, you should realize that ***non-regulation of a nonadmitted insurer means a consumer could be uninsured.***

Now, California law conforms with Dood-Frank and the Insurance Commissioner may request full and complete information regarding an unadmitted carrier's financial stability, reputation and integrity. Based on this information, a surplus lines agent may be blocked from writing business with a nonadmitted carrier. Given this scenario, further transactions by this agent would be a violation and a misdemeanor. Surplus lines brokers are also now required to file a written report within 60 days of placing insurance with a nonadmitted insurer detailing the identity of the insurer, insured, a description of the risk and other pertinent information. Additionally, surplus lines brokers must also prove they tried to place insurance with an admitted carrier before turning to the surplus market.

Of course, while these new regulations help to minimize consumer exposure to the risk of using a nonadmitted insurer, a failure is still possible and when one occurs the Insurance Commissioner may be unable to make an offshore insurer comply with reimbursements to uninsured consumers.

## 4. Distribution Systems

Companies may further be classified by their marketing or distribution systems, such as:

**A. Direct** Writers (or ***Direct Response***), companies that market by mail, phone, and /or the internet with their own employees.

**B. Agencies** are companies formed to represent insurance products. An exclusive or captive agency, represents only one company.

C. **Independent** Agency, agents represent and are appointed with several companies.

D. **Managing General Agent** (MGA), any person, firm, association, corporation, or partnership who manages all/part of an insurer's business. MGAs act as an agent and can underwrite up to **5%** of the insurer's annual policyholder surplus and may adjust or pays claims in excess of an amount determined by the Commissioner as well as negotiate reinsurance on the insurer's behalf.

E. **Home Service,** also known as "debit" companies, sell small face amount policies and "industrial" insurance.

## 5. Fraud and Prevention

The Department of Insurance, Division of Enforcement, has created the Fraud Division to enforce the provisions of the Code and to identify and ***combat insurance fraud***. The business of insurance involves many transactions that have the potential for abuse and illegal activities. This division is intended to permit the full utilization of the department so that they may more effectively investigate and discover insurance frauds, halt fraudulent activities, and assist and receive assistance from federal, state, local and administrative law enforcement agencies in the prosecution of persons who are parties in insurance frauds.

Note: Preventing all types of insurance fraud significantly reduces the cost of insurance premiums.

The following statement is required on all claims forms in California:

"Any person who knowingly presents ***false or fraudulent claims*** for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Note: An insured signing a fraudulent claim form may be found ***guilty of perjury.***

It is unlawful to do any of the following:

- Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation
- Present or cause to be presented a knowingly false or fraudulent written or oral material statement in support of, or in opposition to, a claim for compensation for the purpose of obtaining or denying any compensation
- Knowingly assist, abet, conspire with, or solicit a person in an unlawful act under this section.

Anyone who commits fraud can be punished in one or more of the following ways:

- Imprisonment in a county jail for one year
- Imprisonment in the state prison, for two, three, or five years,
- Required to pay a fine that could be as high as **$150,000** or required to pay a fine that's double the value of the fraud (whichever is higher)
- Required to pay restitution for any necessary medical evaluations or treatment services
- Possibly required to pay for the costs of the investigation

Note: Anyone who has had a prior felony conviction will also receive an extra **2**-years for each prior conviction in addition to one of the penalties mentioned above.

**A. The National Automobile Theft Bureau**

Every insurer in California is required to report covered automobiles involved in theft and salvage total losses, including the vehicle identification number to the National Automobile Theft Bureau (NATB) or a similar organization engaged in automobile loss prevention.

**B. The Arson Information Reporting System**

The **Arson Information Reporting System** was created to permit insurers, law enforcement agencies, fire investigative agencies, and district attorneys to deposit arson case information in a common database within the Department of Justice.

**C. Fraud and Workers Compensation**

When an insurer or rating organization knows or reasonably believes it knows the identity of a person or entity whom it has reason to believe committed a fraudulent act relating to a workers' compensation insurance claim or insurance policy, including any application, the insurer, or agent authorized by an insurer to act on its behalf, or rating organization shall notify the local district attorney's office and the Fraud Division of the Department of Insurance.

**D. Insurance Claims Analysis Bureau**

An insurance claims analysis bureau performs the following functions:

- Collect and compile information and data from members or subscribers concerning insurance claims.
- Disseminate information to members or subscribers relating to insurance claims for the purpose of preventing and suppressing insurance fraud.
- Promote training and education to further insurer investigation, suppression, and prosecution of insurance fraud.
- Provide, without fee or charge, to the Commissioner, all California data and information contained in the records of the insurance claims analysis bureau in furtherance of the prevention and prosecution of insurance fraud.

# Insurance Licensing

**Objectives**

This unit discusses how to obtain and maintain an insurance license, the importance of keeping accurate financial records, and which actions could result in suspension or revocation of a license. As future licensees, it is important to know that all of your actions as an insurance Producer will be checked through the Commissioner's office and honesty is critical to the longevity of your business.

## 1. People Required to have an Insurance License

California requires the following people to obtain an insurance license:

### A. Producers

**Insurance Agents** (also known as producers) is a person authorized, by and on behalf of the insurer, to transact all classes of insurance other than life, disability or health insurance.

Producers sell and negotiate insurance policies to applicants and handle ongoing coverage with clients. Unless the producer has the proper license, they can't sell, solicit, or negotiate any class of insurance.

A **Life Licensee** is a person authorized to act as a life agent on behalf of a life insurer or disability insurer to transact life insurance, accident and health insurance, or life and accident health insurance.

A **Life-Only Agent** is a person authorized by and on behalf of a life insurer to transact the following types of life insurance:

permanent (whole life) life, temporary (term), group life, universal life, credit life, deferred and variable annuities (variables require registration with the NASD),funeral and burial life and long term care.

An **Insurance Broker** means a person who, for compensation and on behalf of another person, transacts insurance other than life, disability or health with, but not on behalf of an insurer.

**Life Agent vs Life Analyst**

Life agents acts on behalf of a life insurer and is paid by the insurer. Life analysts (private consultant) acts on behalf and is paid by someone ***other than an insurer.***

**Authority: Agent vs. Broker vs. Solicitor**

California law defines and insurance agent as someone authorized by an insurer to transact all forms of insurance except life insurance . . . that would be a task reserved for a life-only agent. "Insurance broker" means a person who, for compensation and on behalf of another ***person***, transacts insurance other than life with, but not on behalf of, an insurer. Know that there is ***NO life broker or NO health broker***. An **Insurance Solicitor** is a natural person employed to aid an insurance agent or insurance broker in transacting insurance other than life. There is ***no life solicitor*** license.

The selling of health, disability, workers compensation, credit disability, twenty-four hour coverage and long term care insurance requires an **Accident and Health License.**

A **Life Settlement Broker** works for a fee or commission to negotiate a life settlement . . . sometimes called viatical settlements . . . between an owner and provider. A ***life settlement*** is the selling of a life insurance contract before the insured dies. The life settlement broker represents ONLY the owner and owes a fiduciary duty to work in his best interest. A life insurance producer who has been licensed for one year or longer may act as a life settlement broker. A life producer with less than one year experience may instead take a special 15-hour life settlement class to transact this business. Licensees licensed to act as a viatical broker as of 12/31/09 are considered to have met life settlement licensure. Licensed attorneys, CPAs and accredited financial planners are not required to be licensed to transact life settlements as long as their compensation is NOT paid directly or indirectly by the settlement provider.

Here are a few other insurance job categories:

- The **Broker** helps put together the insured's policy (any line of insurance except Life).
- The **Solicitor** brings in prospective clients for the Producers or Brokers (any line of insurance except Life).
- The **Consultant** makes recommendations to the insured for a fee.
- The **Life and Disability Insurance Analyst** advises (for a fee) an insured or a person named as a beneficiary by a Life or Disability policy. The fee must be agreed upon in writing and any agreement should disclose that some services may be obtained direct from the insurer at no

cost. Further, any commissions from products sold should also be disclosed.

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- The **Administrator** works with Life insurance, Health insurance, and Annuities. Their duties include, collecting premiums and adjusting or settling claims.

Note: Legally, none of these people can sell, solicit, or negotiate insurance unless they're licensed or authorized to work under a Producer. If someone does transact insurance without a license, they can be fined up to **$50,000** and/or put in jail for up to **1** year.

Any person who ***transacts insurance without a valid license*** is guilty of a misdemeanor and could be fined up to **$50,000**, or imprisoned for a year, or both.

Future producers have to pass a written exam that tests knowledge of the different classes of insurance, the duties and responsibilities of Producers, and the state's statutes and rules.

People who want to be involved in certain kinds of insurance aren't required to take the final licensure exam—though they may still end up taking some form of test of knowledge. For example:

- Livestock
- Mortgage
- Travel and transportation
- Credit Life
- Credit Health

- Baggage, Trip Cancellation, and Interruption
- Lender's Property
- Motor Vehicle Physical Damage
- Mechanical Breakdown
- Credit Involuntary Employment

**Interstate Commerce**—You can't sell in other states unless you have a license in that state.

Title 18, Section 1033-1034 legislation (1994) says that certain **prohibited persons cannot participate in the business of insurance** (selling, reinsuring or the role as an officer, director or employer of an insurer) unless they have received written consent of the Insurance Commissioner. A **prohibited person** means any person who has been convicted of a felony, dishonesty or breach of trust. **Conviction** means a finding of guilty or plea of guilty or no contest in a criminal court of the U.S. **Felony** means a crime for which the maximum punishment exceeds one year incarceration. **Dishonesty** includes perjury, bribery, forgery, counterfeiting, making false statements, deception, fraud, schemes, material misrepresentation and failure to disclose material facts. **Breach of trust** means crimes of misuse, misapplication or misappropriation. The **penalty** for violating the above section is a fine of **not more than $50,000 for each violation** OR the amount of compensation the person received for the prohibited conduct (whichever is greater) or **imprisonment for not more than 10 years or both**. **Failure to inform** the Department of Insurance of a prior felony conviction on a license application could result in a violation of this statute and /or constitute grounds for denial of an insurance license.

Note: The CIC defines "***Transact***" when applied to insurance as any of the following:

- Solicitation
- Negotiations preliminary to execution
- Execution of a contract of insurance

- Any dealings before/after the execution of a contract, or any matters arising from the contract

## 2. Licensing Examination

Future producers have to pass a written exam that tests knowledge of the different classes of insurance, the duties and responsibilities of producers, and the state's statutes and rules.

People who want to be involved in certain kinds of insurance aren't required to take the final licensure exam—though they may still end up taking some form of test of knowledge. For example:

- Livestock
- Mortgage
- Travel and transportation
- Credit Life
- Credit Health
- Baggage, Trip Cancellation, and Interruption
- Lender's Property
- Motor Vehicle Physical Damage
- Mechanical Breakdown
- Credit Involuntary Employment

Applicants can take the state's examination after completing one or more of the following requirements:

- Attend a class taught by an authorized instructor (*yawn*)

- Watch a video on prelicensing, licensing, and insurance (*double yawn*)
- Complete a valid and verifiable online prelicensing course, preferably through an association as knowledgeable and fun-loving as ***Affordable Educators***

Pre-examination Licensing Training includes:

- **40** hours of instruction in **Property and Casualty Insurance**
- **20** hours of instruction in **Life Only**
- **20** hours of instruction in **Accident and Health**
- **12** hours of instruction in **Code and Ethics**
- **20** hours of instruction in **Personal Lines**
- **20** hours of instruction in **Limited Lines Automobile**

## 3. Resident and Nonresident

A **resident** producer lives in the state they transact insurance for, whereas, a **non-resident** producer doesn't live in the state that they transact insurance for. If you get that one wrong on the final exam, we're coming to your house to slap you in person.

If someone wants to transact in another state, they have to obtain a license in their home state before becoming a nonresident producer.

All **non-resident** producers have to apply to the NAIC. The Commissioner acts as the Attorney-in-fact after the application is

accepted. This means the Commissioner handles any legal actions brought against the non-resident producer.

The Commissioner can also arrange a reciprocal agreement, exempting certain people from taking the prelicensing examination. This agreement means that if someone from another state is allowed to transact insurance in California, then a California insurer will be allowed to transact insurance in that other state.

## 4. Temporary License

The Commissioner can issue a temporary license to someone before they've completed the final examination. The temporary license is valid for a maximum of **180** days.

A temporary license is granted if:

- A producer dies or is physically/mentally unable to follow through on their duties, a spouse or legal representative can obtain a temporary license to either give the producer time to recover or train their replacement.
- A producer enters into active military duty, a temporary license can be issued to allow the replacement producer time to train and obtain a license.
- The Commissioner revokes a producer's license and a temporary license needs to be issued, in order to give the replacement time to train and obtain their own permanent license.

The Commissioner can limit the temporary licensee's authority or revoke the license at any time.

## 5. Responsible Producers

California requires all producers to engage in honest and responsible insurance transactions. A producer has to meet certain qualifications before becoming licensed, such as:

- Be **18** years or older
- Establish a residence and business in the state of California
- Not committed a felony involving dishonesty or breach of trust (A violation of Title 18, United States Code, Section 1033-1034)
- Completes Pre-licensing Training from an approved school, college, or university registered with the Department of Insurance and received a Completion Certificate verifying educational hours (valid for up to **3** years)
- Passes the state examination with a score of **70% or above**
- Pays the required fees
- Apply to the National Association of Insurance Commissioners (NAIC) Uniform Application. The Commissioner will send an Examination Eligibility Notice, which is valid for 180 days once approved

Note: Prohibited persons, such as felons, must request written consent from the Commissioner, pay a fee, provide all documentation, and receive consent prior to engaging in any business. It is a criminal offense, punishable by civil penalty up to **$50,000** for each violation, and imprisonment for up to **5** years, to employ or permit prohibited persons to participate in the business of insurance without consent.

The Commissioner may require additional information in some cases.

Businesses applying for Producer status must pay all applicable fees; plus, they are required to designate one person as the business' state rules and regulations compliance specialist.

## 6. Producer Appointment

Producers have to become affiliated with an insurer before they can transact insurance. Once someone is an affiliated producer, they represent the insurer, not the insured.

Being affiliated or appointed by a company basically means they hire a producer to sell their insurance. Just because you're licensed, doesn't mean you can immediately start selling your own brand of insurance: you need to represent an established insurance company.

Licensed insurance producers only represent the insurer that appointed them. They can't write policies or represent other insurers if they haven't been appointed. That being said, it's possible for a producer to be appointed by more than one company, and then they can transact insurance for each company.

*Note: If a producer hasn't been appointed or affiliated, they can't legally transact insurance, even if they're licensed.*

## 7. Termination of Appointment

An insurer may Terminate, or cancel, a Producer's Appointment or Affiliation at any time; however, the insurer must notify the

Commissioner within **15** days of the termination. The Termination Notice needs to specify the reason(s) for termination and either be delivered in person or mailed to the Producer's last known address. Whoever initiates the termination (either the insurer or Producer) is responsible to notify the Commissioner within **15** days of the effective termination date.

The insurer is exempt from notifying the Producer of an Appointment termination if the insurer ceases to sell insurance or if the termination is a mutual agreement.

The insurer can also terminate a Producer without written notice if any of the following occur:

- The license is denied, restricted, revoked, suspended, or cancelled
- The business is sold, transferred, or merged
- Bankruptcy is filed
- Fraud or intentional misconduct takes place

A licensee may surrender a ***license for cancellation*** by delivery to the Commissioner, or by written notice of the intent to cancel.
A license ***terminates*** upon the death of the licensee, or when an licensed entity ceases to exist or is otherwise terminated or dissolved. A co-partnership however may continue to transact insurance if it files an application notify the Commissioner of the change in membership within **30** days.

A Producer may terminate an Agency Appointment at any time as long as the Commissioner and insurer are notified.

If a policy of insurance is issued regarding that application, the insurer is considered to have authorized the agent to act on its behalf, and the insurer is responsible for all actions of the agent that relates to the application and policy, as if the agent had been appointed. This has to happen no more than **14** days after the life agent submits an application for insurance to the insurer for which the insurer issues a policy. The insurer shall forward to the commissioner a notice of appointment of the life agent as the insurer's agent. However, nothing obliges an insurer to accept an application for underwriting from a life agent.

At the same time, a licensed life agent who is NOT appointed with a life insurer can't:

- Present a proposal to a prospective policyholder for insurance with that insurer
- Transmit an application for insurance to that insurer if the insurer requires all its life agents to represent only that insurer or a group of affiliated insurers of which that insurer is a member

Except when performed by a surplus line broker, the following acts are misdemeanors in California:

- Acting as agent for a non-admitted insurer to transact insurance
- Advertising a non-admitted insurer to transact insurance
- Aiding a non-admitted insurer to transact insurance

In addition to any other penalties, the person might have to pay **$500** to the state, as well as **$100** per each month the person continues the violation.

## 8. Obtaining a License

Here are the necessary requirements that must be completed if someone wants to obtain an insurance license in California:

### A. Qualifications

Individuals in pursuit of a California insurance license must prove their qualifications to the Commissioner of the Department of Insurance.

*Title 18, Section 1033-1034 legislation (1994) says that certain* ***prohibited persons cannot participate in the business of insurance*** *(selling, reinsuring or the role as an officer, director or employer of an insurer) unless they have received written consent of the Insurance Commissioner. A* ***prohibited person*** *means any person who has been convicted of a felony, dishonesty or breach of trust.* ***Conviction*** *means a finding of guilty or plea of guilty or no contest in a criminal court of the U.S.* ***Felony*** *means a crime for which the maximum punishment exceeds one year incarceration.* ***Dishonesty*** *includes perjury, bribery, forgery, counterfeiting, making false statements, deception, fraud, schemes, material misrepresentation and failure to disclose material facts.* ***Breach of trust*** *means crimes of misuse, misapplication or misappropriation. The* ***penalty*** *for violating the above section is a fine of* ***not more than $50,000 for each violation*** *OR the amount of compensation the person received for the prohibited conduct (whichever is greater) or* ***imprisonment for not more than 10 years or both****.* ***Failure to inform*** *the Department of Insurance of a prior felony conviction on a license application could result in a violation of this statute and /or constitute grounds* ***for denial of an insurance license.***

So, the Commissioner will deny an application for any license if:

- The applicant isn't qualified

- Granting the license isn't in the public's best interest
- The applicant doesn't intend to actually engage in business
- The applicant doesn't have a good business reputation
- The applicant lacks integrity
- The applicant has been refused a professional, occupational or vocational license or had such a license suspended or revoked
- The applicant wants the license in order to avoid enforcement of insurance laws in California
- The applicant has knowingly or willfully made a misstatement in a document or application for a license, or a false statement in testimony given under oath before the Commissioner
- The applicant has previously engaged in a fraudulent practice or a dishonest manner
- The applicant is incompetent and untrustworthy
- The applicant has knowingly misrepresented the terms or effect of an insurance policy or contract
- The applicant has failed to perform a duty or has committed an act expressly forbidden
- The applicant has been convicted of:
    - A felony
    - A misdemeanor by this code or other laws regulating insurance
    - A public offense involving a fraudulent act or dishonesty in acceptance, custody or payment of money or property

- The applicant helped someone else do something which could result in the suspension, revocation or refusal of a license
- The applicant has permitted any person in his employ to violate any provision of this code
- The applicant has violated any provision of law under authority conferred by license
- The applicant submits a fake certificate to the Commissioner

Note: A judgment, plea or verdict of guilty or a conviction following a plea of “nolo contendere” is considered to be a conviction, so it’s best not to set even one toe in a courtroom.

In addition, the following acts could result in suspension or revocation of a license:

- The licensee makes the client cosign, or make a loan, investment, or gift of their policy
- The licensee talks the client into making them the beneficiary under the terms of any intervivos or testamentary trust, or the owner or beneficiary of a life insurance policy or an annuity
- The licensee talks the client into making them or any of their buddies a trustee under the terms of any intervivos or testamentary trust
- The licensee, acting as power of attorney for the client, used their position in order to buy insurance for the client that would give the licensee a commission

Note: All of the above no-no's are so obvious, we're surprised they didn't include:

- Don't shove people into traffic
- Don't steal food stamps from poor people
- Don't incite mass riots

But just in case any of those rules surprised you, we mean it, *don't*.

**Producer** applicants may eventually be qualified to receive a license in one of the following areas:

- Life Only Insurance
- Accident and Health Insurance
- Variable Life Insurance
- Fire and Casualty Insurance
- Personal Lines Insurance
- Limited Lines Automobile Insurance

**B. Written Consent**

If a person who has been convicted of a felony or engaged in dishonest activity deemed inappropriate by the Commissioner, he/she may ask for Written Consent to transact insurance. The Commissioner will review each individual situation and, if applicable, establish rules or procedures for the individual to follow. If the person does not follow the Commissioner's mandates or commits other dishonest acts, he/she may not be able to transact insurance in the state of California.

**C. Exemptions and Exceptions**

The following people don't have to be licensed:

- An insurance company and its employees that are indirectly involved in insurance transactions. This includes an underwriter, loss control, inspection, processing, or claims settling employees
- Administrative, clerical, customer service, those in the position of receiving insurance premium, taking claims and requesting change
- A Producer or representative of a Fraternal Benefit Society, which is a non-profit group that provides Life and Health Insurance to its members. The Producer must not devote more than **50%** of his/her time to selling insurance, plus not sell more than **$50,000** of Life insurance coverage in a year.
- People who train others to become Producers and do not actually sell, solicit, or transact insurance
- An Attorney-in-fact who represents a Reciprocal Insurer, or an employee of the insurer or attorney
- A Real Estate Licensee who sells Home Protection or Warranty Insurance
- People who advise others regarding insurance, but do not solicit its sale

## 9. Maintaining a License

An individual is required to do the following in order to maintain their California insurance license:

### A. Agent Records

A life agent must keep the following records in an orderly and readily available manner for 5 years. Records must be delivered to the Commissioner within 30 days when requested:

- Original application or copy
- Premiums received for each policy
- Records of all policies sold in previous 5 years
- Commissions for each policy
- Record of any other agents involved in the transaction
- Correspondence, proposals, etc sent to the policyholder by insurer and agent
- Copies of written policy comparisons
- Outline of coverage copy

**B. Continuing Education**

The Continuing Education Requirement promotes trustworthy and competent insurance agents for benefit of the public. All resident licensees must fulfill California's Continuing Education Requirement. An insurance license remains in effect (unless revoked or suspended) as long as applicable fees are paid and the Continuing Education Requirement is fulfilled.

This requirement does not apply to those persons holding resident licenses for any kind or kinds of insurance for which an examination is not required, nor shall it apply to any limited or restricted license the commissioner may exempt, or licensed nonresident agents who comply with the continuing education requirements or brokers of their state of residence.

Note: A licensee is exempt who submits proof satisfactory to the commissioner that he or she has been a licensee in good standing for **30** continuous years in this state and is **70** years of age or older.

Each new licensee is responsible for obtaining educational credit hours through approved instructional methods.

Upon renewal, these licensees must comply with the following requirement:

- Life-Only Agents -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance, including 3 hours of ethics.
- Accident and Health Agents -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance, including 3 hours of ethics.
- Life-Only and/or Accident & Health PLUS Property and Casualty Agents. -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance, including 3 hours of ethics.
- Life-only agents who sell annuity products to individual consumers must complete **8** hours of initial annuity training PRIOR to soliciting for sales. A **4** hour refresher annuity training must be taken every subsequent two years prior to license renewal.

The courses or programs of instruction that meet the standards for continuing educational requirements, and the number of classroom hours for which they are equivalent, are as follows:

- Any part of the Life Underwriter Training Council (**LUTC**) Course Curriculum totaling **50** hours, including the health course totaling **26** hours
- Any part of the American College **CLU** diploma curriculum totaling **30** hours

- Any part of the Insurance Institute of America's Accredited Advisor in Insurance (**AAI**) program totaling **25** hours
- Any part of the American Institute of Property and Liability Underwriters' Chartered Property Casualty Underwriter (**CPCU**) professional designation program totaling **30** hours
- Any part of the Certified Insurance Counselor (**CIC**) program totaling **25** hours
- Any insurance-related course approved by the curriculum board and the commissioner taught by an accredited college or university per credit hour granted totaling **15** hours
- Any course or program of instruction or seminar developed or sponsored by an authorized insurer, recognized agents' association, or insurance trade association, or any independent program of instruction, if approved by the curriculum board and commissioner, qualify for the number of hours assigned
- Any correspondence course approved by the curriculum board and commissioner qualify for the number of classroom hours assigned

## C. Special CE Requirements

- **Ethics:** Every licensed agent must complete a minimum of three hours in specially-approved courses in ethics every renewal period. NOTE: This requirement is PART OF not in addition to the continuing education hours required and discussed above.
- **Annuities**: Every life agent who sells annuities shall complete an **annuity eight hour certification** course BEFORE soliciting or selling clients. Thereafter, **four hour certification refresher annuity training** must be taken **every two years** prior to license renewal. NOTE: This

requirement is PART OF not in addition to the continuing education hours required and discussed above. NOTE: Agents CANNOT use the 8-hour annuity training course to satisfy the 4-hour annuity refresher training.

- **Long Term Care:** Every agent who sells long term care insurance OR accelerated death benefit riders to life policies with LTC benefits must complete an long term care **eight-hour certification course** BEFORE soliciting or selling long term care insurance. Thereafter, an **eight-hour certification long term care course** must be taken each renewal period. However, if the agent has been in business **less than 4 years, he must take** an eight-hour long term certification care course every year for the first 4 years in business in order to be certified to solicit and/or sell long term care. This does not increase the total continuing education hours required and discussed above.

**Selling LTC Accelerated Benefits or Riders?**
If the policy you sell has accelerated benefits that involve long term care services, you need to take the 8-Hour Long Term Care Training. If accelerated benefits do not involve long term care, you do not need this special training.

- **California Partnership for Long-Term Care (PR):** Fire and casualty broker-agents and life-only and accident and health agents who wish to solicit individual consumers for the California Partnership product must (prior to being authorized); complete one specifically designated LTC training course and one specifically designated PR course.

  Maintaining authority to solicit individual consumers for the Partnership Product requires:

- An **8**-hour specifically designated LTC training course (2004LTC) each year and must be accompanied by either a **4**-hour PR course every **12**-month period or an **8**-hour PR course every **2**-year license term.

- **Worker's Compensation:** Any life agent who wishes to sell **24-hour coverage** shall complete a course, or seminar of an approved continuing education provider on workers' compensation and general principles of employer liability. Satisfactory completion of this requirement is by proctored examination, administered or approved by the department.

Any person **failing to meet the requirements** and who has not been granted an extension of time within which to comply by the commissioner shall have his or her **license automatically terminated** until the time that the person demonstrates to the satisfaction of the commissioner that he or she has complied with all requirements.

Where a **person cannot perform the requirements** due to a **disability or inactivity** due to special circumstances, the commissioner will provide a procedure for the person to place his or her **license on inactive status** until the time that the person demonstrates to the satisfaction of the commissioner that he or she has complied with all of the requirements.

***D. Agency Name / Change of Address or Place of Business / Printing License # on Business Cards***

An agent may file for an ***agency name*** (fictitious name or DBA) to be approved by the DOI. The name cannot be similar to others or mislead others into thinking the agent is a government entity, motor club or an insurance company.

Every licensee and every applicant for a license shall **immediately notify the Commissioner** in writing of any change in his address.

Every licensee shall prominently affix or cause to be printed on business cards his ***license number*** in a type and size that is at least as big as address and phone.

## 10. License Renewal, Nonrenewal and Fees

Not less than 60 days before a license will expire, the commissioner will mail, to the latest address of record, an application to renew the license for the succeeding license term. **It is the licensee's responsibility to renew** whether or not a renewal notice is received. (The commissioner may accept a late renewal. Application for renewal of a license may be **filed on or before the expiration date**. The application for **renewal of an expired license** may be filed up to one year later. The regular fee and a **delinquent fee** of **50%** of the regular renewal fee apply. Unless a license is suspended or revoked, a licensee **who has applied to renew** a license is entitled to continue operating under the existing license for **60 days after its specified expiration date**, or until notified the renewal application is deficient, whichever comes first, if the applicant has satisfied all license renewal requirements, including:

- The submission of the applicable renewal application and fee on or before the expiration date of the license.
- The satisfaction of all required continuing education or training requirements.

### A. Military Service

If a licensed person enters the military service of the United States and is in the service at a time of a Renewal application, the filing of such application is waived, and the license held shall remain in force during the period of such military service and until the end of the license year in which he is released from such service but not for less than **6** months after such release. During this period a person can file an application and pay the fee without taking an examination or paying any penalty.

## 11. Suspension and Revocation of License

The Commissioner may suspend or revoke any license for any of the grounds on which he may deny an application. A suspension or revocation may be with or without notice or hearing based upon the reason for action.

The following are grounds for suspension or revocation:

- Providing false or misleading information in the license application
- Violating any insurance laws or rules
- A violation committed by a partner or associate that was known or should have been known by the Producer
- Fraudulently obtaining or trying to obtain a license

- Mishandling money received through insurance transactions
- Intentionally misrepresenting the terms of a policy
- Having been convicted of a felony or misdemeanor where the Producer (or license applicant) was dishonest or breached the trust of others
- Fraudulently transacted insurance
- Demonstrated dishonesty in a business's financial matters
- Had a license revoked or suspended in another state (U.S. or Mexican) or Canadian Province
- Forged another person's name on an insurance document
- Cheated on the license examination
- Knowingly transacted business with an unlicensed individual
- Failure to pay a civil penalty or any fees to the Commissioner
- Failure to comply with the Continuing Education Requirement
- Refusal to renew a license by the Commissioner

An accused Producer can request a hearing from the Commissioner. The Producer will have an opportunity to defend him/herself and will receive any decisions in writing.

## 12. Records Maintenance

It is the obligation of each life, life and disability, and disability insurance agent and any other agent and insurer to preserve and maintain all applicable records in his or her possession, in addition to those records transmitted to the insurer, at his or her principal place of business for a minimum of **5** years. The records must be kept in an orderly manner, readily available, and open to inspection or examination by the commissioner at all times.

### A. Reporting of Actions

If any administrative action has been taken against a Producer, he/she must report it to the Commissioner no later than **30** days after the final disposition or no later than **30** days of the initial pretrial hearing date in the case of criminal prosecution. The Producer must include all relevant documentation, including a copy of the court order, any complaints filed, plus the results of any hearings.

### B. Assumed Business Name

Every individual and organization licensee and every applicant for such a License, shall file with the commissioner in writing the true name of the individual or organization and also all fictitious names under which he conducts or intends to conduct his business and after licensing shall file with the commissioner any change in or discontinuance of such names. The commissioner may disapprove the use of any true or fictitious name.

## 13. Fiduciary Responsibilities

**All funds received** by an insurance agent, broker, or solicitor, life agent, life analyst, surplus line broker, special lines surplus line broker, motor club agent, bail agent, permittee, administrator, or solicitor, as premium or return premium for any policy of insurance, are held in a fiduciary capacity. Any person who diverts or appropriates those fiduciary funds to his or her own use is guilty of theft and punishable for theft as provided by law.

**Producers** accept payment for insurance premiums, plus handle money from business and personal use.  It is extremely important

that these premium funds are placed in a separate trust account and do not end up being mixed with other funds, except money used for the following:

- Advancing premiums
- Keeping reserves to refund premiums
- Paying bank charges and fees
- Paying for any other costs arising out of the process of receiving and returning premiums

A Producer must keep a **Client Trust Account** in the form of a checking account, demand, or savings account and fiduciary funds deposited into this account. If the insured makes the payment payable the insurer, the Producer must forward it directly to the insurer.

**Producers/agents** must establish and maintain records in an appropriate accounting system for all client payments received. The **Commissioner** may request to see these records at any time during the **Producer's** business hours. If the **Producer** does not make these records available or maintain client premium fund records for **3** years following the policy cancellation date, serious consequences can result.

When receiving cash from a client for premium payments, the **Producer** must take the following steps:

- Give the person a receipt showing the amount of money paid, the date and time, the policy number, plus the policy holder's name

- Deposit the money into a **Client Trust Account**
- If the **Producer** does not have such an account, he/she must convert it into a money order, certified check, or cashier's check made out to the insurer
- Keep records of all money received and forwarded

## *END OF SECTION*

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes A red flashing button will warn you.**

# Section LO 9

# INSURANCE TERMS & LAW

# Insurance Terms and Concepts

**Objectives**

Insurance has a language of its own: in Life insurance, Health insurance, Property insurance, and in Casualty insurance, as well as Individual or Group. We'll look at some of the common terms in this unit, but refer to the glossary for additional information.
This unit includes:

- General Terms and Concepts (no big mystery there)
- More Terms and Concepts

## 1. General Terms and Concepts

Just so you know, In California, the word:

- "Shall" means mandatory
- "May" means permissive
- "Person" means any individual, association, organization, partnership, business trust, limited liability company, or corporation.

Note: Any provision of the code can be sent out by mail. Or, if not prohibited, sent by ***electronic transmission.***

Here are some general terms and concepts you're going to frequently run into when dealing with insurance:

**A. Insured**

In Life insurance, the **insured** is the person on whose life an insurance company writes a policy. The insured and the policyowner may not be the same person.

In Property or Casualty insurance, it usually means the "named insured," or the one(s) named on the policy.

**B. Insurable Interest**

**Insurable interest** is required in the purchase of insurance to protect against an economic loss.

In **Life insurance**, the insurable interest has to exist when someone first applies for the policy.

In **Property** and **Casualty** insurance, insurable interest has to exist at the time of loss.

**B. Insurable Events**

**Insurable Events** are any contingent or unknown event, which may indemnify a person having an insurable interest, or create a liability against him, may be insured against.

**C. The necessary Elements in a Policy**

All insurance policies must contain:

1) Information about the parties involved in the contract
2) Description of the property or the life insured
3) The insured's insurable interest
4) Information about the risks the insurance covers

5) The policy period
6) Premium rates

Note: The financial rating of the insurer is not required.

### D. Principle of Indemnity

The Principle of Indemnity is the restoration to the approximate financial position occupied prior to the loss, in whole, or in part, by payment, repair, or replacement.

### E. The Law of Large Numbers

The Law of Large Numbers is a theory regarding probability. The Law of Large Numbers states that:

1) If you take a random sample from a larger population, it's more likely to represent the whole, than if you took a random sample from a smaller population.
2) The more people there are, the more the chance of risk increases.

### F. Loss Exposure

**Loss Exposure** is defined as someone's potential for loss, or their loss exposure/exposure to loss. For example, a homeowner in a particular region of the country will have different kinds of exposures than a homeowner in another region. They may be more vulnerable to hail, tornadoes, or forest fires, so they have a higher exposure to loss to those particular perils.

Exposure is measured in **exposure units**, for which the price of insurance is the rate.

## G. Adverse Selection

Adverse Selection is selection against an insurer by insuring more poor than good or average risks, and the tendency of poorer risks to buy and maintain insurance. By practicing adverse selection, insurance companies can more ***profitably distribute their exposure to loss.***

## H. Concealment

Concealment is the withholding of facts or information by an applicant or insured that may materially affect the decision regarding an insurance risk.

## I. Risk

Risk is the chance of loss. The term "risk" is often used in a general way to designate the entire subject matter of insurance covered under a policy or upon which an application for insurance has been received. Risk is also sometimes used to designate a policyholder (e.g. poor, standard, etc.).

There are **2** categories of risk:

1) **Pure Risk** is defined as the uncertainty as to whether or not a possible loss will actually happen. There could be a loss, but no one knows when or how. A pure risk is the chance of loss only.
2) **Speculative Risk** is a loss that's more predictable, such as gambling, business ventures, or playing the stock market. Speculative risk assumes that, based on the

person's actions/decisions, a loss is inevitable. A speculative risk also has the chance of gain.

Note: Insurance only protects against pure risks.

### J. Ideally Insurable Risks

The following criteria describes an ideally insurable risk:

- The loss must be **measurable**
- The loss must be **accidental**
- The loss must be **predictable**
- The **law of large numbers** has to apply
- The loss must create **financial hardship**
- Insurance must be **affordable and practical**
- The loss must not be **catastrophic**

### K. Risk Management Methods

There are **4** Risk Management methods used to deal with the uncertainty of loss:

1) **Avoid** the risk
2) **Reduce** or control the risk
3) **Retain** the risk
4) **Transfer** the risk (insurance)

### L. Hazard

Hazard is any factor that creates or increases the chance of loss. There are different types of **hazards**:

- A **physical hazard** is created by the condition, occupancy, or use of the property itself. Examples include faulty breaks that increase the chance of collision, and faulty electrical wiring that increases the chance of fire.

- A **moral hazard** is a characteristic of the insured that increases the chance of loss. Examples include arranging an accident to collect the insurance, or inflating the amount of a claim.
- A **morale hazard** is carelessness or indifference to a loss because of the existence of insurance. One example is leaving the car keys in an unlocked car.
- A **Legal Hazard** is created by decisions or actions of the courts. If something could result in big, expensive lawsuits, this is considered a legal hazard.

## M. Peril

Peril refers to the specific event causing a loss, such as fire, windstorm or collision.

## N. Fraud

**Fraud** is the intentional and fraudulent omission, or the communication of information of matters, proving or tending to prove false, and entitles the insurer to rescind.

## O. Concealment

**Concealment** is the neglect to communicate ***known information***, whether intentional or unintentional. Concealment entitles the injured party to rescind.

Information you aren't required to communicate includes information that is:

- Already known or ***should be known***
- Information which the other ***party waives***

- Information ***excluded by a warranty and not material to the risk***
- Information that is ***excepted from insurance and not material to the risk***
- Information based on ***personal judgment***.

Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance.

## P. Rescission

**Rescission** means the same as revoke or remove. An ***insurer has the right to rescind*** an insured's policy if:

- There's been intentional or unintentional concealment
- There's been an intentional and fraudulent omission
- A misrepresentation comes to light after a policy has gone into effect
- A material warranty or a material policy provision has been violated

***Concealment,*** whether intentional or unintentional entitles the injured party to rescission of a contract

## Q. Materiality

Materiality has to do with facts and information relevant to an insurance policy. Materiality can be determined using **3** questions concerning the information:

1) Can the information convince or dissuade either party to enter a contract?
2) Does the information create a disadvantage for either party?

3) Does the information have any affect on the risk or insurability involved?

Materiality concerns both the insurer and the insured. Each party involved in the contract has to have all the relevant information that could have any positive or negative affect on the contract.

NOTE: Materiality is to be determined not by the event, but solely by the ***probably and reasonable influence*** of the facts on the party to whom the communication is due.

## R. Representations

**Representations** are statements on an application that the applicant represents as true and accurate, to the best of their knowledge and belief. Representations may be considered to be an implied warranty.

A ***representation may be altered or withdrawn before the insurance is effected, but not after***. A representation is considered false when the ***facts fail to correspond*** with its assertions or stipulations.

**Misrepresentations** are the false representation of the terms or benefits of a policy by an agent, or an applicant who falsely represents the health or other condition of the proposed insured.

## S. Warranty

A **warranty** is a statement made by the applicant that becomes a condition of the contract. False warranties allow the other party to ***rescind entire contract***.

Alert!

Warranties do not apply to Life insurance. No statement made on a Life insurance policy is ever considered to be a warranty. The final exam will definitely try to trick you on that one

*A warranty is either:*

- **Expressed** warranties are in written form and attached to the policy.
- **Implied** warranties are not written but still exist under the law. ***Representations cannot qualify as an express provision*** in a contract, but ***may qualify as an implied warranty***

## T. The Law of Agency

**The Law of Agency** is the authority of one to act as the agent of another, the insurer, with one of **3** types of authority:

1) **Express Authority**, what is spelled out in the contract
2) **Implied Authority**, what is assumed to exist
3) **Apparent Authority**, what is by conduct or action

## U. Loss

Loss may refer to the claim itself, the amount sought in a claim, the reduction in value of an insured's property, or the amount paid on behalf of an insured under an insurance policy.

The **2** categories of loss are:

1) **Direct loss**, which is a loss that is the direct result of an insured peril.
2) **Indirect loss**, which is a subsequent loss, such as being unable to use a building after a fire.

## V. Liability

Liability is something for which you are legally responsible.

Liability insurance provides coverage and pays for losses to other people and their property caused by negligence.

## W. Negligence

Negligence is the result of carelessness, thoughtlessness, or inaction, but it's never intentional.

Before a court will award any damages to an injured party due to another's negligence, the **4** elements of negligence must be present:

1) **Legal duty** means the person has a legal responsibility to take the necessary precautions to avoid being negligent.
2) **Breach of duty** means the person failed to uphold their legal duty.
3) **Damage or losses** occurred as a result.
4) **The breach of duty** caused the damages or losses.

Here's a surreal story to help you remember the **4** elements:

Bob decided to put quicksand outside his driveway. He thought to himself, "I should really tell people about this here quicksand." (Legal duty)

When Gwen was walking by, she said, "Is that safe?"
Bob forgot about the quicksand, and said, "Yep. Safe as safe can be!" (Breach of duty)

Trusting him, she went on her way, and was promptly sucked into the quicksand. Luckily, she just happened to have a copy of "How to Escape from Quicksand," so she survived, but she still lost one of her tennis shoes. (Damages or losses)

"Hey," she said, "I lost one of my tennis shoes because you said it was safe!" (Damages or losses caused by the breach of duty)

True, it's a weird story, but we're sure you'll remember the **4** elements of negligence long after you've developed senility and forgotten everything else.

Note: If these **4** elements of negligence are present, the injured party has a good chance of winning a lawsuit.

### X. Accident

Accident is an unforeseen and unintentional act identifiable in time and place.

### Y. Occurrence

Occurrence is an event that results in a loss.

### Z. Reinsurance

Reinsurance is the transfer of risk between insurance companies. Used in both Life and Health, as well as Property and Casualty, it's an agreement or "treaty" between insurance companies where one company may transfer, and one company will accept, all or part of the risk of loss of the other. The ***primary insurer*** (ceding company) is the company that is transferring its loss exposure to another insurer (reinsurance company).

## 1. From the Top!

You may have noticed that we've run out of letters of the alphabet. Well, we're too enterprising to let that stop us! We'll just start over again! (Problem-solving!)

### A. Cancellation

**Cancellation** is the termination of coverage in the policy period by the insurer.

### B. Lapse

**Lapse** is the termination of coverage for non-payment of premium. A policy will lapse at the end of the grace period.

### C. Renewal

**Renewal** is the continuation of coverage from one policy period to the next. **Non-renewal** is termination of coverage at the end of the policy period.

### D. Unearned versus Earned Premiums

Unearned versus earned premiums are based on whether or not someone has paid for future coverage.

If someone pays an annual premium, and six months have gone by, then they have six months of:

- **Unearned premium**, for the six future months that are prepaid
- **Earned premium**, for the six months that have already gone by

### *E. Binders*

A **binder** gives the insured temporary coverage. An insured may have just requested or applied for the insurance, and he/she doesn't actually have the official documentation in hand, but the **binder** means the insurer has agreed to provide temporary coverage pending approval.

Someone can receive a binder and still be denied insurance. If the insurance company gives the person a binder while the insurance application is being processed, that binder doesn't guarantee a certificate of insurance. If the insurance company decides not to insure someone, the company has to issue a legal notice of cancellation. Until then, the binder will continue to provide coverage.

Note: Binders are not used with Life insurance.

# Insurance Law

## Objectives

A contract is defined as: “a legal document between 2 or more parties, in which a certain performance is promised, in exchange for a valuable consideration.” In this unit we’ll discuss the elements of a contract, as well as other contractual terms that apply to insurance.
This unit includes:

- The Elements of a Legal Contract (C.L.O.C)
- Different Kinds of Contracts
- Legalities

### 1. The Elements of a Legal Contract (C.L.O.C)

There are certain elements that make a contract a legal contract, and therefore a legally binding contract. The term legally binding means that the terms of the contract will be upheld by a court of law.

There are **4** important elements to a legal contract:

1) **Competent Parties** means the people entering into the contract have to be considered “legally capable” (of age, mentally stable, etc.).
2) **Legal Purpose** means a contract has to have a lawful purpose. If it doesn’t have a lawful purpose, it’s not enforceable.
3) **Offer and Acceptance** means both parties agree on the terms of the contract and now the contract is considered legally binding.

4) **Consideration** means the physical return both parties get from the contract. In insurance terms, the consideration the insurer gets is premium payments, and the consideration the insured gets is insurance coverage.

Fun with Mnemonics:
We can't think of anything that's more fun than a mnemonic! Well…okay, so there's a couple of things that are more fun than a mnemonic, but only one or two. What was that? We need to reevaluate our definition of fun, is that what you said? Shows what you know! Let's *party*!

The elements of a legal contract spell **C.L.O.C**.:
**C**ompetent parties
**L**egal Purpose
**O**ffer and Acceptance
**C**onsideration

That gives you an easy way to remember it. See? Fun, fun, fun!

## 2. Different Kinds of Contracts

There are different characteristics of insurance contracts that can change the entire tone of the contract. These include the following:

### A. Contract of Adhesion

This kind of contract means "take it or leave it." In this type of contract, one party has all the bargaining power, and the other party has no bargaining power. This type of contract doesn't allow for negotiation or quibbling over contract wording.

### B. Aleatory Contract

This kind of contract means the amount of money paid by one party could be a lot more or less than the other party. Most insurance contracts are considered Aleatory contracts, because the insured could make premium payments for years for an occurrence that never happens, or the insurer could end up compensating an insured after only a few premium payments.

### C. Unilateral Contract

This kind of contract means that someone promises to do or not do something in return for consideration. This is also referred to as a "one-sided contract." A very simplified example of this would be: if you pay me $500, I'll paint your house.

### D. Conditional Contract

This type of contract depends entirely on an event actually happening. An easy example of this is if someone is selling their house, they won't get paid until the house actually sells.

### E. Personal Contract

This type of contract insures the person, and not the property. This applies in Life and Health insurance.

## 3. Legalities

Here are some important legal characteristics affecting contracts:

### A. Indemnity

This refers to a type of contract, such as insurance, that serves to restore the individual to the approximate financial position occupied prior to the loss.

### B. Representations/Misrepresentations

**Representations** are statements made by the applicant for insurance before the policy is issued. These statements aren't considered set in stone: usually the wording is "true and correct to the best of my knowledge."

If the information turns out to be incorrect, this is called a **misrepresentation**. Intentional **misrepresentations** can void an insurance policy, because it affects the determination of potential risks.

Putting it into Context:
Here's an example of intentional **misrepresentation**: Chris's Health insurance application asked if Chris has any family history of heart problems. Chris is completely healthy, but there is an extensive history of heart problems in Chris's immediate family. Worried that checking "yes," would affect her premiums, Chris checked "no." If the producer/agent finds out about Chris's intentional misrepresentation, it could keep Chris from being insured, or it could void Chris's policy.

Note: A representation can be corrected and/or withdrawn before a policy has gone into effect. Once the policy has gone into effect, a misrepresentation can void the policy.

### C. Warranties

A **warranty** is a statement made by the applicant that becomes a condition of the contract. False warranties void the entire contract.

Alert!

Warranties do not apply to Life insurance. No statement made on a Life insurance policy is ever considered to be a warranty. The final exam will definitely try to trick you on that one (all you potential Life agents out there).

A warranty is either:

- **Expressed** warranties are in written form and attached to the policy.
- **Implied** warranties are not written but still exist under the law. Some representations may qualify as implied warranties.

## D. Concealment

**Concealment** means withholding important information regarding a loss or the events surrounding a loss. Concealment immediately voids coverage.

## E. Insurable Interest

**Insurable interest** is required in the purchase of insurance to protect against an economic loss.

In **Life insurance**, the insurable interest has to exist when someone first applies for the policy.

In **Property** and **Casualty** insurance, insurable interest has to exist at the time of loss.

## F. Waiver and Estoppel

**Waiver** is the giving up or surrendering of a known right or privilege.

**Estoppel** is the legal principle that holds that anyone whose words or actions have caused a waiver of a right or privilege, can't later reclaim the waived right or privilege if a third party has relied upon it.

For example, Angie's house burns down and she loses everything. Because she's having a really difficult time coming up with an inventory of items lost to submit her proof of loss form on time, her insurance company tells her they'll give her an extra 30 days to submit the form. Even though the insurance company has the legal right to demand the form by a certain date, they are **waiving** that right.

**Estoppel** is a court/judge blocks someone from asserting the original right they chose to **waive**. The exact definition of this can be along the lines of: If someone behaves in a manner that's inconsistent with their behavior in the past. This is a very circuitous way of saying, "if someone goes back on their word," but look out for that answer on the final exam.

An example of **estoppel** would be if Angie's insurance company suddenly changed their minds and said they wouldn't reimburse her loss because she didn't submit her Proof of Loss on time. Angie takes the company to court and the judge issues an

**estoppel**, which forces the insurance company to honor the conditions of the **waiver**.

### G. Rescission

**Rescission** means the same as revoke or remove. An insurer could legally rescind an insured's policy if:

- There's been intentional or unintentional concealment
- There's been an intentional and fraudulent omission
- A misrepresentation comes to light after a policy has gone into effect
- A material warranty or a material policy provision has been violated

### H. Utmost Good Faith

Insurance policies are considered contracts of **utmost good faith**, which basically means all parties involved were completely honest and disclosed any and all relevant information and facts. Utmost good faith means mutual trust during the negotiation of a contract.

## 4. Tort Law

**Tort** means a civil wrong for which the law provides a remedy. A simple way of looking at this is that a tort has more moral than legal implications, but someone who has been wronged can still turn to the law for protection and compensation. There's such thing as an intentional tort, which means someone intentionally wronged someone else.

Note: Someone who commits a tort is called a **tortfeasor**.

The differences between tort law and contract law stem from the fact that tort law deals with civil wrongs, and contract law protects against and handles legal wrongs.

## *I. Insurance Contracts Are Different*

There are ***six specifications*** that make insurance contracts different from other legal contracts.

- The parties between whom the contract is made (insurers / insured)
- The property or life insured
- The interest of the insured (does he have an insurable interest?)
- The risk insured against (life, health, disability, etc)
- The period during which insurance is to continue (is there a grace period?)
- Statement of premium (monthly, quarterly, etc) and Premium rate changes (will the premium change based on reaching a certain age, income, etc)

NOTE: The ***financial rating of an insurer*** (A.M. Best , Fitch, Moody's or Standard & Poor's) is not required to be specified in the insurance policy.

**Insurance Terms For Review**

***Application*** – Information on the insured for the review of the insurer. The application is made part of the contract.

***Policy*** -- The collection of documents, applications, and other papers that spell out the insurance coverage, the premiums, the benefits and other legal aspects of the insurance.

***Rider*** – Specific provisions that are attached to the policy.

***Grace Period*** – If a payment is missed, the time allowed before a policy is cancelled.

***Cancellation*** –The termination of coverage.

***Lapse*** – Termination of coverage for non-payment of premium.

***Rate*** – A metric that determines a higher risk associated with a particular insured.

***Premium***—The payment that buys a set amount of insurance. Earner & Unearned Premium – Earned is the premium paid for the six months that have already gone by. Unearned is a prepaid premium for the six months in the future.

*End of Section*

***. When you have studied ALL required minutes for this section, click the blue button at right***

***to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

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# Section LO 10

# ETHICS & TRADE PRACTICES

# Introduction to Code and Ethics

## Objectives

This section will prepare you for examination questions regarding basic code and ethics knowledge. If you take our 12-Hour Code and Ethics training, you will study this subject in even greater depth.

### 1. Historical Background

The following timeline illustrates and explains important court decisions and events in the history of **Insurance Regulation** in the United States. You will come across many of these events again in your study of insurance and further down the road when you are a licensed agent.

#### A. Early 19th Century

There were no specific laws or regulations in place other than the individual state laws that governed corporations and private businesses. There were no state insurance laws on the books and no federal regulation of the industry. Resulting improprieties and abuses lead to a demand among the industry for regulation.

**B. 1850**

New Hampshire is the first state to establish a state **Insurance Commissioner**—still a very important office now. The states of Massachusetts, California, Connecticut, Indiana, Missouri, New York and Vermont soon appoint state Insurance Commissioners.

**C. 1868**

A Supreme Court decision in the case of **Paul vs. Virginia** rules that insurance is not interstate commerce. This establishes that states actually have the right to regulate insurance and not the federal government.

## D. 1871

The **National Association of Insurance Commissioners** is formed. The **NAIC** seeks some uniformity with regards to state insurance regulation and reporting requirements. The organization also develops regulations concerning the solvency of insurance companies and methods for the exchanging of information between states.

**E. 1905**

In New York, the **Armstrong Investigation** of insurance is conducted to improve regulation and lessen abuses.

## F. 1910

Again in New York, the **Merritt Committee Investigation** of fire insurers leads to greatly improved state regulation and a new state insurance code.

### G. 1939

The state of New York adopts a rule that states all insurance companies doing business in New York *must* comply with the insurance laws of New York with regards to any state they do business in.

## H. 1944

Another very important Supreme Court decision concerning ***Paul* vs. Virginia.** The **South-Eastern Underwriters Case** causes the U.S. Supreme Court to overturn **Paul vs. Virginia**, and rules that insurance was indeed interstate commerce when conducted over state lines and that federal anti-trust laws applied to the industry. The effect of this ruling left the industry virtually unregulated.

### I. 1945

The **McCarran-Ferguson Act (Public Law 15)** is passed by Congress due to strong opposition against federal regulation of insurance. **This law gave back to individual states the right to regulate and tax insurance to the extent that it is not regulated by the federal government.** This is a landmark moment in the history of insurance regulation, and the **McCarran-Ferguson Act** is still an important law today.

## 2. Federal versus State Regulation

Current federal influence of the industry includes regulation by the Security and Exchange Commission (SEC) and the National Association of Securities Dealers (NASD) for securities regulation of certain insurance products; and the Internal Revenue Service (IRS) for tax code provisions regarding

products and companies. Pension legislation with regulations from the Labor department such as ERISA, protects plan participants and their beneficiaries. Health insurance legislation, such as the standardization of Medicare supplement policies, as well as long term care insurance, are areas of overlapping regulation by states and the federal government. The sale of insurance products in the banking industry will involve their regulatory organizations, The Federal Reserve and the Office of the Comptroller of the Currency.

Like any other industry, there is debate concerning the influences of federal versus state regulation.

Proponents of **Federal** regulation argue that:

- State regulation is not uniform which, leads to inefficiencies and other tangles. Despite improvement led by the NAIC's model legislation, this situation is unlikely to change.
- State regulation is ineffective in controlling insurance companies that operate on a nationwide basis.
- Federal regulation would be more effective as well as cheaper.

Proponents of continued **State** regulation argue that:

- State regulation is satisfactory, more flexible and capable of meeting individual state insurance needs. There is no real proof that federal regulation would improve conditions or be more efficient.
- The voluntary cooperation of state insurance departments has already made great strides in achieving uniform provisions.

- If federal regulation were imposed, it would lead to two regulatory systems instead of one cohesive system.

The future is likely to see more federal influence of the industry, however it is unlikely to become the sole regulator in all matters relating to insurance.

In state legislatures, and in Congress in recent years, there has been proposed legislation and passed legislation regarding current Life and Health insurance issues including; a tax on the cash value build-up in a life policy, certain mandated benefits such as Family or Maternity leave, privacy and authorization with HIPAA.

## 3. Ethics and History

The overall purpose of regulation is to **protect the public good** and the insurance consumer.

The state insurance department seeks to provide protection by regulation regarding three primary areas:

1) Company authorization and financial stability or solvency
2) Agent licensing and education
3) Sales practices

These regulations set minimum standards and form the basis of **ethical guidelines** by making certain actions unlawful. There remains a difference however between law and ethics. Witness the business scandals such as **Enron** and **World Com**, breaches in

ethical behavior in the securities industry in spite of penalties that include prison as well as fines or civil penalties.

**California Codes & Ethics**

The California Insurance Code (CIC) and California Code of Regulations (CCR) identify many unethical or illegal practices, but they are NOT a complete guide to ethical behavior. In fact, An action may be lawful, but unethical.

Today, higher legal standards for the benefit of consumer protection will likely find an agent or company liable for their actions. Public perception of the industry has been affected by scandal, insolvency, class action lawsuits, and their own personal experiences.

How then, do insurance agents live up to higher expectations and responsibilities? To tell someone "Do the right thing", may be too simplistic. A personal ethical or moral code is required to answer the question of what one should do in a given situation.

Ethical or moral codes have long existed, a universal norm being "The Golden Rule", a version of it expressed by most religions including Christianity, Judaism, Islam, Hinduism, Buddhism, and Confucianism.

Ethics is the basis for trust, promises, and reliability in our business. Accepting ethics at the philosophical level is one thing, living the practicality of it in business daily is another. The evolution from insurance agent to insurance professional, and the responsibility of that role may help.

There are **7** requirements for recognition as a professional:

1) Specialized knowledge not understood by a lay person
2) Academic study of the subject
3) Licensing examination is required
4) Professional organization or society
5) Independence in their recommendations
6) Public recognition as professionals
7) A code of conduct (ethics)

Professional organizations include the National Association of Insurance and Financial Advisors (NAIFA), Society of Financial Service Professionals, the Million Dollar Round Table (MDRT), the American College, sponsor of the professional designations; Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC) and Life Underwriting Training Council Fellow (LUTCF). Other designations in the industry are the Charted Property Casualty Underwriter (CPCU), and Certified Financial Planner (CFP).

All of these organizations have a code of conduct, code of ethics, or pledge, that have as it's common theme, a recognition of obligations and responsibilities to those they serve:

- The best interests of the client come first
- Obey the law
- Loyalty to the company
- Professional conduct, truthfulness, confidentiality
- Duties to other professions, family, and self

Many of the regulations in our industry have to do with sales practices. Suitability, disclosure, sales illustrations, and replacement, the particulars of which you will learn later in units that follow, are the issues that concern regulators, companies, and ourselves as professionals.

The solicitation, selling, and servicing of insurance properly, may be accomplished by following some basic principles:

- Identify yourself as you are without misleading titles
- Use illustrations and sales materials properly
- Provide options or choices in recommendations
- Record all information requested on the application
- Protect client confidentiality
- Deliver the policy and explain things to your client
- Service with a regular review

Even so, the best professionals realize that mistakes are made, clients fail to remember what was once explained, and complaints occur.

Professional liability or malpractice insurance is a must today, and the professional agent carries **Errors and Omissions (E&O) coverage** for even a baseless lawsuit. If you are sued and the other party wins, E&O coverage will pay the loss, subject to policy limits and a deductible, in addition to defense costs.

An agent's exposure may be in one or more of several areas:

- Alleged misrepresentation of policy terms and coverages
- Misuse of policy illustrations

- Improper licensing for product
- Misunderstanding of tax ramifications
- Downside risk that is not explained
- Premiums or premium offset arrangements
- Incorrect information on an application
- Failure to provide proper coverage
- Inappropriate or unsuitable product recommendations

Agents can protect themselves with documentation of client files with copies of; checklists, questionnaires, factfinds, agendas, notes, illustrations, disclosures, and phone logs. Maintaining client contact is important in the relationship also, and many agents use birthday or greeting cards, client newsletters, and periodic reviews to stay in touch.

# Marketing and Trade Practices

**Objectives**
This unit will cover the Code and Ethics concerning the selling of insurance products in California. The purpose of Regulation concerning the Marketing of Insurance products is to ensure that all insurance companies act in good faith, abstain from deception and that they treat all members of the public with honesty and fairness in all insurance matters. While this is common sense in all business practices, there are several concepts and regulations that are particular to the insurance business.

## 1. Illegal and Unfair Practices

Insurance products are regulated to make sure that all members of the public are treated with honesty and fairness. Obviously, that's

business ethics 101, but there are regulations specific to the insurance industry that could end up on the final exam.

With regard to the marketing or claims handling of insurance products, the following are defined as unfair methods of competition and unfair and deceptive acts or practices:

**Penalty for Violation of the Unfair Practices Act**

Section 790 of the CIC established rules for unfair methods of competition or unfair deceptive acts, including false statements in advertising, misleading representations about a company's financial strength, misrepresenting the terms or nature of an insurance contracts as an inducement to buy, discriminating among individuals of the same class, delaying or refusing to pay claims and more (see below).

The insurance commissioner has sole discretion to establish what constitutes a violation of the Unfair Practices Act. The penalties will range between $5K and $10K per act

## A. Misrepresentation

Misrepresentation means any of the following:

- Misrepresenting the terms of a policy, its dividends, the financial condition of an insurer, or making any misrepresentation to any policyholder insured in any company in order to induce them to lapse, forfeit, or surrender their insurance
- Making untrue or misleading statements
- Entering into any agreement to commit any act resulting in unreasonable restraint, or monopoly in the business of insurance

- Publishing or circulating false statements of financial condition in order to deceive
- Making false entries or willfully omitting any material facts in order to deceive
- Making or allowing any unfair discrimination
- Stating that the named insurer is a member of the California Insurance Guarantee Association, or stating that the insurer is insured against insolvency
- Canceling or refusing to renew a policy in violation of the code

### B. Premiums

There are **3** main illegal practices regarding premiums:

1) **Commingling** means company money is mixed with the customer's money or the agent's money.
2) **Overcharging premiums** involves overcharging the insured and then keeping the excess.
3) **Charging premiums for unapplied coverage** means a producer accepts premium payments for coverage that isn't in effect.

### C. The insurance License

It's illegal to transact insurance without a license, and it's illegal to obtain a license fraudulently. It's also illegal to sell insurance that's outside the scope of the license you have. If a producer is licensed to sell Property and Casualty insurance, they can't transact a Life insurance policy. So, just to reiterate:

- It's illegal to transact insurance without a license
- It's illegal to obtain a license fraudulently
- It's illegal to sell insurance outside the scope of your license

### D. Rebating

**Rebating** means you use a sales inducement to get a prospective customer to buy an insurance policy. This could involve guaranteeing a dividend, splitting commissions with the client, or paying premiums for the client.

### E. Illegal Inducement

This is a nice way of saying bribing somebody. It could mean giving gifts to prospective clients, offering them money, or even buying them nice dinners. Offering special contracts or changes to a contract or policy is also illegal, as well as offering prospective clients foot massages or a free phrenological assessment. Illegal, illegal, illegal.

### F. Concealment

**Concealment** involves intentionally withholding facts or information to gain an advantage in an insurance transaction.

### G. Twisting

**Twisting** means any situation where the truth is twisted or bent to get someone to drop an existing policy for a new policy. For example, if a producer could get a commission by convincing a client to drop their existing life policy, which takes care of all their needs, for a new policy they might not necessary need, the producer is engaging in twisting.

### H. Defamation

The official definition of defamation is the malicious discrediting or slandering of an insurance company or its agents. Basically, it's saying/writing/implying something mean that could hurt a company/individual's reputation or cost them money. For example: "Buy from us, because unlike our competitors, we don't reek of day old cheese!" Usually it's harsher than that, but you get the general idea.

### I. Controlled Business

You can't get a license just to write controlled business, which means you're only selling to friends and family. You can write some controlled business, but there are guidelines regarding controlled business:

- In a **2**-year period no more than twice the amount of a producer's premiums can be from controlled business
- A producer can't have twice the amount of controlled Life and Health policies, than they have for noncontrolled premiums

### J. Free Insurance

This would fall under "inducement," but the CIC specifies that Free Insurance is a no-no. Basically, someone would offer free insurance as a benefit of buying an annuity or a property.
Agents/producers/insurers aren't allowed to do this.

Note: The prohibitions of free insurance doesn't include insurance written in connection with newspaper subscriptions or general circulation. It also doesn't include insurance issued to credit unions or members of credit unions.

## 2. Misrepresenting Policy Provisions

It's considered a misrepresentation of policy provisions if an insurance company or producer:

- Fails to disclose policy benefits during a claim
- Denies a claim because the insured fails to exhibit property without proof of demand
- Denies a claim because the insured didn't act within time frames that weren't in the policy
- Requires a release beyond the scope of claim for the payment of the claim
- Issues payment checks for partial settlement that releases the insurance company of it's total liability
- Makes payments to the insured that requires reimbursement if the company doesn't tell the insured about that policy

## 3. Unfair Claims Settlement practices—2695.1

The following are considered specific unfair claim settlement practices. An insurance company can't:

- Misrepresent facts or policy provisions
- Fail to respond promptly to a claim
- Fail to properly investigate a claim
- Refuse to pay a claim without an investigation
- Fail to affirm or deny coverage after Proof of Loss is provided
- Refuse to act in good faith when payment is reasonably clear
- Fail to offer reasonable settlement amounts, forcing the insured to resort to litigation or arbitration
- Delay processing a claim with excessive paperwork
- Delay settlement under one coverage as leverage to effect the settlement under another coverage for that policy

- Deny a claim without providing the insured with a clear explanation
- Discriminate against claimants who are represented by a public adjuster
- Fail to honor checks paid to claimants
- Fail to pay a claim promptly after settlement
- Fail to promptly deliver a release or settlement document to the insured of claimant
- Delay or add to the cost of Property/Casualty appraisals
- Fail to make a good faith effort to settle and force the insured into a Property and Casualty appraisal
- Settle directly with a claimant who's represented by an attorney without the attorney's consent
- Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than **60** days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage.

Note: This **60**-day period doesn't include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

## 3. Prompt, Fair, and Equitable Settlements Definitions

### Claimant (Fair Claims Settlement Practices)

The ***claimant*** is any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant – 2695.2(c) CCR

***Notice of legal action -- 2695.2(o) CCR***

means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding.

***Proof of claim —(2695.2(s) CCR***

means any evidence or documentation in the possession of the insurer, whether as a result of its having been submitted by the claimant or obtained by the insurer in the course of its investigation, that provides any evidence of the claim and that reasonably supports the magnitude or the amount of the claimed loss.

**D. File and Record Documentation– 2695.3 (a) CCR**

Every licensee's claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files shall contain all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined.

**E. Duties upon Receipt of Communications—(2695.5(a) CCR**

Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested.

Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to

require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

## 4. Standards for Prompt, Fair and Equitable Settlements--2695.7(a) CCR

These are the standards for prompt, fair, and equitable settlements by insurance companies.

No insurer shall discriminate in its claims settlement practices based upon the claimant's:

- Age
- Race
- Gender
- Income
- Religion
- Language
- Sexual orientation
- Ancestry
- National origin
- Physical disability
- Address or location

After receiving proof of claim, every insurer has to:

- Accept or deny the claim as quickly as possible, and no later than **40** calendar days
- Notify the claimant if more time is required to determine whether a claim is going to be accepted or denied, either partially or wholly. The claimant needs to be notified every 30 days if more time is needed

- Settle the claim by making a reasonable offer—insurers can't make an offer that's unfair or unreasonably low

Note: If someone thinks they have received an offer that's too low, they can file a complaint with the Commissioner. The Commissioner shall consider any admissible evidence offered in determining whether or not a settlement offer is unreasonably low.

- Pay any approved claims no later than **30** calendar days

## 5. Insurance Information & Privacy Legislation

**The Gramm-Leach-Bliley Act (1999)** concerns consumer financial privacy and financial safeguards: ***Financial Privacy --*** Requires financial institution to provide each consumer with a privacy notice explaining what information is collected about the consumer, where the information is used and how it is protected. Any changes must be disclosed. Prohibits the sharing of nonpublic information with a non-affiliated third party unless consumers are given an opportunity to opt-out. ***Financial Safeguards --*** Requires financial institutions to develop a written security plan describing how the company is prepared for and plans to protect consumer nonpublic information, even if the consumer is no longer with the financial institution.

**The California Financial Information Privacy Act (2003)** adds to the financial privacy provisions of Gramm-Leach Bliley by requiring that consumers ***opt-in*** PRIOR to any sharing of nonpublic information among financial institution non-affiliates. Consumers can ***opt-out*** for any sharing of information among affiliates of the financial institution.

**Insurance Information and Privacy Protection Act (2003)** provides that personally identifiable information supplied to an insurance agent or broker in order to apply for insurance must be protected. Agents must provide consumers with a privacy Notice explaining how and with whom this information will be shared and the consumer right to ***opt-out*** from having personal information shared.

**Health Insurance Portability and Accountability Act (HIPPA)** assures that an individual's health information (medical records) by

establishing national standards for health providers, billing services and health information companies. Requires covered entities to take reasonable steps to ensure confidentiality of communications, notification of record use and document privacy policies and procedures.

HIPPA also establishes protections for certain people – called HIPPA Eligible Individuals" – when they lose group health coverage. Once eligible, they are guaranteed an offer of at least two health insurance policies that do not impose pre-existing condition exclusion periods. HIPPA is silent on the charges for these policies.

**Life Settlement Transactions** in California have many built-in privacy protections for consumers. Medical information for these transactions may not be disclosed unless it is necessary to effectuate a sale AND the owner of the policy and the insured give written consent; OR it is in response to an investigation by the insurance commissioner; OR it is a previously agreed condition of the sale between the owner and provider; OR it is necessary to allow the provider / agent to make contact for purposes of determing the health status of the insured.

**Selling To Seniors?**

In California, marketing life, annuities, or disability to seniors who are **65** years or older, have specific regulations. Policies have to include a **30**-day free look period, a written comparison of any existing health coverage, and the person has to receive advice concerning HICAP's free services to seniors (the Health Insurance Counseling and Advocacy Program). ***Seniors are particularly vulnerable*** because they may be at an age where do not comprehend, hear well, see clearly or they are just plain gullible. A special code of ethics should be exercised when selling products to seniors.

## 6. The Insurance License

It is illegal to sell any insurance product without an official state-granted license to do so. Also, selling insurance that is outside the scope of one's license is illegal. If an agent is licensed to sell

Automobile and Home insurance, they cannot sell or write a Health insurance policy without being licensed for that line. It is also illegal to obtain any insurance license by fraudulent means.

Every licensee shall prominently affix or be printed on business cards, written price quotations for insurance products, and print advertisements distributed exclusively in this state for insurance products, its license number in type, the same size as any indicated telephone number, address, or fax number, as well as the word "insurance".

If someone violates these rules, the person could receive a fine of up to:

- **$200** for the first offense
- **$500** for the second offense
- **$1,000** for the third offense, or any other offenses afterwards

Note: The penalty can't exceed **$1,000** for any one offense.

## 7. Unfair Discrimination

Insurance companies can't deny insurance coverage based solely on the basis of race, religion, national origin, sexual orientation, ancestry or victims of domestic violence. Coverage also can't be denied because of a physical or mental disability.
Law and regulations regarding unfair discrimination state that:

- Insurance companies have to treat all applicants equally
- Insurance companies can discriminate as long as the discrimination is based on **Risk Selection and Sound Actuarial Principles**

Note: **Risk Selection and Sound Actuarial Principles** are methods for determining whether a person or a group of people are desirable insurance risks. This takes into account their age, occupation, gender, lifestyle, and history, but it also looks at a statistical model of certain

demographics. Actuarial principles help companies deduce how much money in claims they could end up spending on claims based on morbidity rates, mortality rates, etc.

Companies are allowed to use the following characteristics only if those characteristics increase the risk of insurance:

- Age
- Sex
- Marital status
- Race
- Creed
- National origin
- Ancestry
- Lawful occupation
- Change of occupation
- Change of domicile
- Previous insurance rejection
- Cancellations/nonrenewals of insurance
- A previous lack of insurance

## 8. HIV

California has established mandatory and uniform minimum standards for insurers to avoid making or permitting unfair distinctions between individuals of the same class in the underwriting of life or disability income insurance for the risks of acquired immune deficiency syndrome (AIDS)and AIDS-related conditions (ARC), for assessing AIDS and ARC risks for determining insurability which are deemed to be sufficiently reliable to be used for life and disability income insurance risk classification and underwriting purposes, and to require the maintenance of strict confidentiality of personal information obtained through testing as well as require informed consent before any insurer tests for HIV.

## 9. Commissions and Fees

Only licensed producers can receive commissions or fees, or any other valuable considerations from insurance transactions. It's

illegal for anyone who isn't licensed to accept a commission. Someone can accept renewals and deferred commissions if they were licensed at the time of the sale.

A service fee is a charge the insurance producer makes that isn't part of premium payments.

Note: Service fees aren't allowed in Personal lines of insurance: Auto, Property, and Liability.

Service fees can be charged in Commercial lines of insurance if the producer provided additional services above and beyond customary practice. In these instances, the producer would have to provide a written explanation for the charge.

You can't accept compensation from the insurance company unless you have done the following, prior to the insured's purchase of a policy:

- Obtained the insured's documented acknowledgement
- Disclosed the amount of reimbursement or provided a reasonable estimate of what that reimbursement might be
- Disclosed the nature of the work that will be done on behalf of the insured

## 10. Advertising

False advertising is illegal. Here are some guidelines concerning advertising:

- Advertising has to be clear and not misleading
- If a company advertises their assets, those assets have to match the last verified statement filed with the Commissioner
- You can't infer or suggest you're an insurer unless you're an insurer
- All advertising has to be true and accurate no matter what form it's in: media, newspapers, magazines, online, and etc.

Note: Advertisements for term life insurance aimed at people who are **55** years or older will:

- Clearly and prominently distinguish basic life insurance benefits from supplemental benefits such as accidental death benefits
- Prominently disclose any limitations, exceptions, or reductions affecting each benefit
- Prominently disclose any condition affecting the policy or certificate holder's continued insurability. If term coverage terminates at a stated age, or at the end of any designated period, that fact and the specified age or designated period shall be disclosed
- Prominently disclose any change in benefits resulting from the aging of the insured, policy duration, or any other factor
- Prominently disclose any change in premium resulting from the aging of the insured, policy duration, or any other factor. If the insurer retains any right to modify premiums in the future, that fact shall be disclosed

### A. Internet Advertising

A person licensed in this state as an insurance agent or broker, who advertises on the Internet, and transacts insurance in this state, must identify all of the following information on the Internet:

- Name as it appears on his or her insurance license, and any fictitious name approved by the commissioner
- The state of his or her domicile and principal place of business
- License number

If someone who advertises on the Internet does any of the following, the California Code considers them to be “transacting” insurance:

- Gives an insurance premium quote to a California resident
- Accepts an application for coverage from a California resident
- Communicates with a California resident regarding terms of an agreement to provide insurance or an insurance policy

## 11. Fiduciary Responsibilities

Producers have certain financial responsibilities. If they receive premium payments on behalf of an insurance company, they have to report the exact amount of the payment and records must be kept on all received/refunded premiums.

Any refunded or returned premium has to be delivered promptly to the insured.

If the producer accepts a premium payment, they have to provide the insured with a receipt for the payment of premium no later than the next business day.

The producer has to deposit premium payments within **7** days of receipt, and if the payment is a check that's made out to the insurance company, the producer has to forward the check directly to the insurance company.

Note: Insurance producers have to keep client records for Property and Casualty insurance for **3** years past the policy's expiration.

If premiums are paid in cash, the insured has to get a receipt, which includes:

- The date
- The name of the agent/producer
- The name of the policyowner/insured
- The amount received
- The insurance company's name
- The policy number

Okay, so some of that is ultra-obvious. Don't roll your eyes at us, we're just being thorough.

Note: Just a quick aside—if there are extra charges relating to someone's policy or application, the insured needs an explanation in writing for those charges.

## 12. Policy Retention

Policy retention benefits everyone. A producer who keeps an open line of communication with his/her clients will have the opportunity for more sales, as well as be able to provide the maximum protection for that client.

It benefits the client because they always have the insurance protection they need. And, obviously, if a producer has a lot of happy clients, this is going to benefit the producer and the insurer financially.

## ***End of Section***

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes A red flashing button will warn you.**

# Section LO 11

# GOVERNMENT PROGRAMS & THE STATE GUARANTEE FUND

## Social Insurance and Government Programs

**Objectives**

While there are many types of **government programs** for public health assistance and social medicine, government has a limited role when it comes to retirement and **Insurance** benefits. In this Unit we will discuss this limited role. We will cover **Social Security**– probably the most well known program in the country by reviewing certain benefits that are paid out to spouses and dependents who survive those who were covered by **Social Security**.

## SOCIAL SECURITY

The Social Security Act was passed in 1935 to provide retirement benefits for eligible workers. It is **funded by a payroll tax on all**

**employers, employees, and any self-employed individuals**. While the benefits provided by Social Security has greatly expanded, this Unit will only cover the **'Old-age, Survivors and Disability' (OASDI)** parts of this government program. (See the Health Insurance course for further discussions of Social Security Medicare benefits and other social health programs).

There are three levels of being covered by Social Security:

pp) Fully insured

qq) Currently insured

rr) Disability insured

***Fully insured*** means that the individual has worked a ***minimum of* 40 quarters (credits)**. As fully insured, an individual can obtain retirement and premium free Medicare Part A benefits. The easiest definition of a 'quarter of coverage' is a calendar quarter for which the individual had a minimum level of payroll earnings when they were employed.

***Currently insured*** indicates the person had at least **six quarters** of coverage during the previous 13 calendar quarters.

**Minimum Requirements For Social Security Disability**

Recent changes require ***additional credits, starting at age 24***, in order to obtain "current status" to qualify for disability benefits. Now, the ***minimum requirement for workers under age 24*** to obtain "currently insured" status is 6 credits in the last three years.

## DISABILITY INCOME

***Disability income benefits are paid*** when the individual is fully insured and also had at least **20 quarters** of specified coverage in the last 40 quarters when their disability occurred. See the table below for a summary of insured status.

| BENEFIT | INSURED STATUS REQUIRED |
|---|---|
| ***Retirement at age 66*** | ***FULLY*** |
| ***Disability*** | ***DISABILITY*** |
| ***Spouse Benefit*** | ***FULLY*** |
| ***Spouse's Survivor Benefit*** | ***FULLY*** |
| ***Child Benefit*** | ***FULLY*** |
| ***Child's Survivor Benefit*** | ***FULLY OR CURRENTLY*** |
| ***Parent's Survivor Benefit*** | ***FULLY*** |
| ***Lump-Sum Death Benefit*** | ***FULLY OR CURRENTLY*** |

## PRIMARY INSURANCE AMOUNT

Social Security benefits are expressed as a percentage of the **Primary Insurance Amount:** the average amount of their earnings. These

numbers are updated and published by the federal government and benefit statement are sent annually.

**RETIREMENT INCOME**

An individual must be a certain age to start receiving Social Security benefits. This age, which has been increased over the years, is known as the **normal retirement age**. This **normal retirement age** is based on one's year of birth.

| *YEAR OF BIRTH* | *NORMAL RETIREMENT AGE* |
|---|---|
| *1943 - 1954* | *66 YRS.* |
| *1955* | *66 YRS., 2 MONTHS* |
| *1956* | *66 YRS., 4 MONTHS* |
| *1957* | *66 YRS., 6 MONTHS* |
| *1958* | *66 YRS., 8 MONTHS* |
| *1959* | *66 YRS., 10 MONTHS* |
| *1960 AND AFTER* | *67 YRS.* |

## SURVIVOR BENEFITS

When a worker passes away who was covered by Social Security, their surviving family members may be eligible for benefits. The **surviving spouse** is eligible at any age if caring for an unmarried child younger than 16 years of age or a disabled child under 22 years of age. If there

are no dependent children, and the widow is under age 60, he or she must wait until age 60 to receive benefits. Known as **the blackout period**, the spouse's survivor benefit will not begin when they reach age 60. (if the spouse is disabled, they can receive this benefit at age 50).

***Income or Death Benefit*** -- based on the wage earner's average lifetime earnings, an eligible survivor may receive a $255 lump sum ***death benefit*** plus a monthly ***income***. The higher the earnings, the higher the benefit. The percentage received depends on the survivor's age and relationship to the wage earner.

An unmarried child of a deceased worker is eligible for a benefit if they are under 18, under 19 if in high school or before 22 if disabled.

A dependent parent who is 62 or over who has received at least half their support for the deceased worker may also be eligible.

A lump-sum death benefit of $255 is paid to the deceased's spouse or dependent child.

## MEDICARE

This is the most familiar social insurance program in the US. Created in 1965, it's meant to provide health care coverage to the elderly and disabled.

**Medicare** claims are handled by the Social Security Administration.

**Medicare** benefit payments are the result of contracts between the **Department of Health and Human Services** and selected insurance companies. These insurance companies are known as **intermediaries**, such as home health providers, hospitals, or hospices. Other insurance companies, known as **carriers**, handle services and claims provided by doctors or other providers.

Eligibility for **Medicare** usually begins with individuals over the age of **65**. Anyone eligible for social security is automatically eligible for **Medicare**. But there are circumstances that allow a person of any age to receive coverage. Those who suffer from kidney failure, no matter their age, are eligible to receive **Medicare** benefits. Also, surviving spouses of those who qualified for social security at the time of their spouse's death would then be entitled to **Medicare** coverage.

**Medicare** is divided into **4 parts**:

1) **Part A** – hospital insurance
2) **Part B** – supplementary medical coverage
3) **Part C** – supplements to existing Medicare coverage
4) **Part D** – a new prescription drug coverage plan

**PART A: Hospital Insurance**

Enrollment in Part A is automatic for anyone who is eligible for **social security**. Individuals become eligible for **Part A** benefits the first day of the month of their **65th** birthday.

**Part A** provides **4 types** of care:

1) Hospital inpatient care

2) Specialized nursing facility care
3) Hospice care
4) Home health care

**Hospital inpatient care** pays for any usual and reasonable charges that are incurred while hospitalized. This benefit pays the full cost of hospitalization up to **60 days** (for each benefit claim period) after the patient pays a deductible.

But, from the **61st** day to the **90th** day, **Medicare** pays a certain coinsurance amount per day.

For stays over **90 days**, the patient may draw upon **60 lifetime reserve days**, which are available only once in a lifetime. After these reserve days are exhausted, the patient's daily co-payment amount increases significantly.

A **benefit period** begins when the patient is admitted, and ends **60 days** after discharge. Any readmission during this **benefit period** would be considered the same **benefit period**; readmission after the **60 days** would be considered the beginning of a new **benefit period**.

**Specialized nursing facility care** benefits are paid up to **100 days** of each benefit period. **Medicare** covers all reasonable charges for the first **20 days**, and then the patient pays coinsurance days **21 through 100**. The nursing facility must be Medicare approved, and the stay must follow a prior hospitalization of at least **3 days**. A physician has to give the order for the licensed nursing professionals providing the nursing care.

**Home health care** benefits are provided when the patient is confined at home and receives certain health services from a participating home health agency. **Medicare** pays this benefit as long as the care is intermittent, as opposed to constant long-term care. The benefits paid by **Medicare** are:

- Intermittent, part-time nursing care
- Occupational, physical or speech therapy
- Home health assistants
- Medical supplies
- Medical social services
- **80%** of durable equipment, such as wheelchairs or home hospital beds

**Hospice care** involves the support of terminally ill patients, and the benefit covers both inpatient and outpatient hospice care. **Medicare** benefits *won't* cover curative treatments. If a physician certifies the need, **Medicare** may provide **Hospice care** for an unlimited period of time. In fact, **Medicare** usually pays all costs related to hospice care, and with no required deductible.

However, there are **2 services** that do require co-payments:
1) **Prescription drugs**—patient pays **5% or 5$** per prescription, whichever is less
2) **Respite care**—patients pay **5%** of Medicare approved rates

**PART B: Supplementary Medical Coverage**

**Medicare Part B** is designed as an optional and supplemental insurance to Part A. Those who are enrolled in Part A are automatically

enrolled in Part B, unless they request otherwise. **Part B** requires a monthly premium payment, and **Part B** always requires the following co-payments:

- The annual deductible amount
- 20% of all reasonable charges for medically necessary services
- The cost of the first three pints of blood used in medical procedures

Note: If **Medicare** deems any expense **medically unnecessary**, then the patient pays for everything.

**Medicare Part B** provides coverage for **3 medical services**:

1) Doctors' services
2) Home health care not covered by Part A
3) Outpatient medical care and supplies

**Doctors' services** include most physicians', surgeons' and osteopaths' medical services and supplies. The care can be received in any type of facility: hospital, skilled nursing facility, physicians' office, at home, or in a clinic. The specific covered services are:

- Medical, surgical and anesthesia
- Office visits and house/hospital calls
- Radiological and pathological services required by a doctor
- Medical supplies ordered by a doctor
- Surgical second opinions
- Diagnostic tests and X rays
- Care provided by a doctor's office nurse
- Physical, occupational, speech therapies
- Blood transfusions

These coverages are specifically **excluded**:

- Routine exams
- Foot care: flat feet or subluxations of the foot
- Eye exams, eyeglasses or contact lenses
- Hearing exams and hearing aids
- Most dental care
- Most immunizations
- Cosmetic surgery (unless needed to repair an accidental injury)

**Home Health Care Services** are provided for people participating in **Medicare Part B** but not Part A. Part B would cover all costs related to medically necessary home health visits. The patient would pay no deductible or coinsurance except for **20%** of the cost of medical equipment.

**Outpatient Medical Services and Supplies** pertain to certain services received as an outpatient from a Medicare approved hospital for the diagnosis and/or treatment of an illness or injury. Part B usually covers:

- Outpatient clinic services
- ER services
- X rays
- Ambulatory services
- Purchase or rental of durable medical equipment used in patient's home
- Artificial limbs or eyes
- Artificial replacements for internal organs (e.g., colostomy bags)
- Neck, back or limb braces
- Splints, casts or surgical dressings

- Blood transfusions (after the first three pints)
- Any outpatient physical, occupational or speech therapy

## SERVICEMEN'S GROUP LIFE INSURANCE

This form of group life insurance provides life insurance to members of *the uniformed armed forces* who are on active duty. The premiums are paid by service personnel and cover mortality costs should they become necessary. The federal government pays any extra premiums charged because of hazardous duty. **SGLI** covers full-time active duty members whose duty is more than 30 days. It also covers the *National Guard, reservists, and the ROTC* while engaged in active duty.

# California Insurance Guaranty Fund

**Objectives**

Guarantee associations are the safety nets of the insurance industry. This unit includes:

- What are Guarantee Associations?
- The California Life and Health Guarantee Association
- The California Insurance Guarantee Association (CIGA)

### 1. What are Guarantee Associations?

**Guarantee associations** protect the public from insolvent insurance companies. An **insolvent insurer** is defined as an insurance company that can't pay their debt. The company might

even be going through bankruptcy. The Commissioner determines if a company is insolvent, which means the company can't fulfill any future financial obligation.

Here's the core of the issue: just because a company becomes insolvent doesn't mean it can stop paying claims. If an insurance company becomes insolvent, and then its clients experience covered losses, those clients still have settlements coming to them.

Obviously, once a company is bankrupt, it doesn't really have the money to pay insureds' claims. Guarantee associations pay insurance claims that an insolvent company isn't able to pay. This protects claimants and policyowners.

**Paid-In Capital** is the sum an insurance company is paid at the sale of its stock. This capital represents the interest of the stockholders in the company.

**Conservation** is when the Insurance Commissioner ("Commissioner"), upon a Superior Court's order, takes over the operations of an insurance company licensed in California. There are many different reasons for the Superior Court to issue such a "Conservation Order", but most of the time it is because the insurance company is insolvent, and the Commissioner must operate the company in order to conserve assets for the benefit of policyholders, creditors, and other persons interested in the assets of the company. As a court-appointed Conservator, the Commissioner may continue as much, or as little, of the insurance business as the Commissioner deems appropriate.

During conservation, one of the Commissioner's main duties is to conduct a thorough examination of the insurance company's books and records to determine whether the company can be rehabilitated so that it may continue operating as a "regular" insurance company (i.e., without the day-to-day management by the Commissioner).

Any insurance company that wants to do business in California is required to belong to one or both of the following guarantee associations:

***A. California Life and Health Guarantee Association***

The **California Life and Health Guarantee Association** is under the Commissioner's authority, and protects annuity policyholders, beneficiaries, and payees of Life and Health policies.

The California Life and Health Guarantee Association guarantees any payments of benefits and continued coverage if an insurance company becomes insolvent. This association guarantees the following:

- **80%** of contractual limitations
- Up to **$250,000** for Life insurance Death benefits
- Up to **$100,000** for cash surrender value
- Up to **$100,000** for the present value of annuities
- Up to **$200,000** for Health benefits

Note: The maximum amount an individual can receive for all policies is **$250,000**. The maximum amount a firm or corporation can receive for all policies is **$5 million**.

The **California Life and Health Guarantee Association** doesn't cover:

- Variable Life or Variable annuities that aren't guaranteed by the insurer
- Risks the policyholder accepted
- Any part of the policy that's reinsured
- Policies issued by a health care service contract
- Anyone that's self-funded or uninsured
- Parts of a policy subject to dividends or experience credits
- Policies issued by an insurer that doesn't have a Certificate of Authority in California
- Any coverage issued by the California Medical Insurance Pool

## B. California Insurance Guarantee Association for Property and Casualty

The **California Insurance Guarantee Association for Property and Casualty** protects Property and Casualty policyowners from insolvent insurance companies.

Every California insurance company that transacts Property and Casualty insurance has to be a member of the California Insurance Guarantee Association for Property and Casualty.

The limits of coverage for all Fire and Casualty (excluding Workers Compensation) are:

- A minimum of **$100**
- A maximum of **$500,000**

The California Insurance Guarantee Association for Property and Casualty pays claims for most types of Property and Casualty policies, including Workers Compensation.

Alert!
There is no limit on Workers Compensation claims. The California Insurance Guarantee Association for Property and Casualty doesn't put any limits on Workers Compensation claims. We're drawing attention to this fact, because we've seen this actual question on the test.

Claims are paid if they are filed within **30** days of a company becoming insolvent. Once the Commissioner receives notification that a company is insolvent, the Commissioner notifies the CIGA within **3** days.

The Commissioner could request that the policyowners also be informed of the insolvency and their rights regarding the insolvency. Claims are paid up to **$500,000**.

Note: Before a company can receive a Certificate of Authority in California, they have to belong to one or both of the CIGA. They won't be able to transact insurance business or appoint any producers until they've done so.

Note: It is a misdemeanor to refuse to deliver any books, records or assets to the Commission pertaining to any insurance company insolvency.

## ***End of Section***

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes A red flashing button will warn you.**

# Section LO 12

## Health Insurance, Long Term Care and Workers' Compensation

**Objectives**

Even though you are studying Life-Only subjects, the State Exam may ask a few health insurance questions. This section is designed to help you plan for this event.

## HEALTH INSURANCE

### 1. Law and Regulations Pertinent to Health Insurance

## A. Post Claims Underwriting

No insurer in California who issues Disability policies that cover hospital, medical, or surgical expenses, can engage in what is known as "postclaims" underwriting. Postclaims underwriting means the rescinding, canceling, or limiting of a policy due to the insured's failure to complete medical underwriting and resolve all reasonable questions from written information submitted on or with an application before issuing the policy.

## B. HIV

Testing for the **HIV** virus can only be done with the written consent of the potential insured party. This consent includes the party to which the results of the test are to be reported to: a physician, the county health department in which the insured resides, or the insured directly. This consent is valid for **6** months and is obtained by the insurance company during the underwriting process, so long as it is prior to any testing for the virus. It must be made known to the potential insured that the test for HIV will be used in the determination of the individual's insurability.

Alert!
When we took the final licensure exam, we ran into this question: "The HIV written consent is valid for ____ months:" We always like to point out the questions we had, just so you can be extra-special prepared.

Any positive test results are to be reported as indicated on the consent form. Any direct disclosure of positive test results has to include information on the California AIDS Hotline telephone numbers to help the person find a doctor or with any questions.

The insurance company may report any positive test result to the **Medical Insurance Bureau**. This report is made in the form of *a* nonspecific abnormality determined by a blood, urine or saliva test.

### C. Incontestability Clause

A Health Insurance policy is considered to be Incontestable after **2**- years from the date of issue. After a **2**-year period, no claims can be denied and the policy can't be canceled for any reason. The only exception to this would be for fraudulent misrepresentation on the individual's application.

## 2. Group Health Insurance

The following are also required in California Group Health policies:

### A. Coordination of Benefits (COB)

This provision limits the total benefits payable to **100%** of all covered expenses when more than one insurance plan is providing coverage. It also establishes the priority of plans for coverage: one plan will be the Primary plan, the other will be the Secondary plan.

The Primary plan will cover all expenses up to the plan's limits. Then, the Secondary Plan will cover all expenses in excess of the Primary plan. A rule of thumb for Coordination of Benefits is that when a plan covers an individual who is an employee or qualified member, that plan is Primary over a plan that covers the same individual as a dependent.

When two plans cover the same dependant (common when parents are divorced), the COB provision outlines which policy will be primary and which will be secondary. The primary plan may be decided by which parent has an earlier birthday in the

year or it may also be decided by which parent has more custody over the child. In either case, coverage for the dependant will not exceed **100%** of the expenses incurred.

## B. Continuation of Benefits

California state law requires **Continuation of Coverage** when an employer is not subject to COBRA requirements. When an employee or other participating member of a Group Health plan is terminated, they can continue coverage under the group policy for themselves and any eligible dependents, so long as the employee or participating member had been covered for at least **3** months prior to termination.

However, the employee would not be eligible for Continuation of Benefits if that person were eligible for Medicare or similar health coverage. This continued coverage has to include only medical and hospital expense benefits. It can exclude expenses for:

- Accidental death
- Dental
- Vision
- Prescription drugs

Continuation of Benefits must be requested in writing within **60** days of termination, or within **60** days of the employee being notified of the right to continued benefits by their employer. This includes any and all COBRA continuation of coverage.

Note: It's too late to make the request, if the person waits longer than **61** days after termination.

A surviving, divorced or separated spouse, who is **55** years or older, can continue the coverage for up to **6** months with adequate payment of premiums. They can do so until they're eligible for Medicare.

Continuation of Benefits ends on the earliest of the following dates:

- End of the period for which the last premium was paid
- The date the group policy ends, unless replaced by another group policy by the employer
- **6** months after the date the group coverage would have ended
- The premium due date after the date the insured becomes eligible for Medicare benefits
- When COBRA policy provisions dictate coverage will end

## C. Termination of Group Disability

If a state-issued Group Disability policy is terminated by an employer or by an insurer, **conversion rights** to an individual policy apply to all employees and dependents, including those who became totally disabled while insured under the policy.

If an insured person dies during the conversion period of a Group Life policy, the amount of insurance is payable as a claim under the Group policy. It is payable regardless if the person did or did not apply for Individual insurance or made the first premium.

## LONG TERM CARE INSURANCE

A chronically ill person qualifies for LTC if one of the **2** following criteria is met:

1) Impairment in **2** out of 6 activities of daily living (ADLs), such as:
    - Bathing
    - Walking
    - Eating
    - Cooking
2) Impairment of cognitive ability

### A. The 4 Levels of Care

There are **4** levels of care considered with respect to LTC policies:

1) **Skilled care** requires the treatment and skills of a licensed professional nurse.
2) **Intermediate care** is provided by skilled medical practitioners, but is obviously not continuous or permanent.
3) **Custodial care** is to help meet daily living requirements and does not require a licensed professional or qualified medical health practitioner.
4) **Home health care** includes skilled nursing care, therapeutic health providers and skilled and/or licensed nursing professionals. It is important to note that no Long-Term Care policy sold in California can only offer nursing home benefits. <u>The LTC policy must be comprehensive</u>.

### B. Advertisements and Marketing LTC

Every insurer providing long-term care coverage in California shall provide a copy of any advertisement intended for use in

California to the commissioner for review at least **30** days before dissemination. The advertisement shall comply with all laws in California. In addition, the insurer needs to keep records of the advertisement for at least **3** years.

California has certain requirements with respect to Long Term Care (LTC) insurance. Every insurer marketing long-term care insurance must:

- Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant
- Train its agents in the use of its suitability standards
- Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner

**Long Term Care Replacement**: If the premium on the replacement product is less than or equal to the premium for the product being replaced, the sales commission shall be limited to the percentage of sale normally paid for renewal of long-term care policies or certificates. Replacement is further contingent upon the insurer's declaration that the replacement policy materially improves the position of the insured.

The agent and insurer shall develop procedures that take into consideration, when determining whether the applicant meets the standards developed by the insurer, the following:

- Can the person afford to pay for the proposed coverage?
- What are the person's unique goals or needs with LTC, and what are the disadvantages and advantages of insurance with regards to those goals and needs?

- If the applicant already has insurance, what is the value, benefit and costs of the existing insurance compared to the value, benefit, and costs of the recommended insurance for purchase or replacement?

Note: It's considered an unfair practice for any insurer, broker, or agent to encourage a policyholder to replace an LTC policy unnecessarily. It's also unfair to cause a policyholder to replace an LTC policy that results in a decrease in benefits and an increase in premium.

**It's the Law!** With regard to long-term care insurance, all insurers, brokers, agents, and others engaged in the business of insurance owe a policyholder or a prospective policyholder a duty of honesty, and a duty of good faith and fair dealing.

An agent, broker, or other person who contacts a consumer as a result of receiving information generated by a **cold lead device** (only a name, address and phone have been obtained through advertising), shall immediately disclose that fact to the consumer.

Additionally, each insurer must:

- Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate
- Establish marketing procedures to assure excessive insurance is not sold or issued

- Submit to the commissioner every six months a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance
- Display prominently on page one of the policy or certificate and the outline of coverage: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

## C. HICAP

HICAP trains volunteer counselors to help seniors with questions regarding Medicare and Long Term Care insurance. All volunteers receive **30** hours of initial training, and continuing education annually. HICAP counselors are there to provide a service only, and do not to sell or endorse any specific type of insurance or company.

HICAP's mission is to help seniors:

- Receive health care benefits
- Understand Medicare's coverage
- Compare Medicare Supplement plans
- Consider HMO options
- Review long-term care and financing choices
- File claims
- Organize their doctor and hospital bills
- Prepare Medicare/HMO appeals and challenge claim denials
- Clarify senior's rights as a health care consumer

Insurers have to give applicants for LTC, information regarding the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides Health insurance counseling to senior Californians for free. The agent needs to provide the name, address, and the local HICAP number, as well as the statewide HICAP number: 1-800-434-0222.

Note: Insurers have to also give the applicant a copy of the LTC insurance shoppers guide. The guide was developed by the California Department of Aging.

Note: If an LTC policy provides benefits for both institutional care and home care, than that LTC policy can be called “comprehensive long-term care” insurance.

### D. California LTC Requirements

Long-term care policies must:

- Cover preexisting conditions that are disclosed on the application no later than **6** months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins
- Provide a free look period of **30** days

### E. California LTC Prohibitions

A long-term care policy can’t:

- Be canceled, nonrenewed, or terminated on the grounds of the age or the deterioration of the mental or physical health of the insured

- Contain a provision establishing a new waiting period in the event existing coverage is replaced by a new insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder
- Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care
- Provide for payment of benefits based on a standard described as "usual and customary," "reasonable and customary," or words of similar meaning
- Terminate a policy, or contain a provision that allows the premium for an in-force policyto be increased due to the divorce of a policyholder
- Include an additional benefit for a service other than the statutorily required home- and community-based service benefits, the assisted living benefit, or a nursing facility benefit, unless the additional benefit provides for the payment of at least five times the daily benefit and the dollar value of the additional benefit is disclosed in the schedule page of the policy.

## WORKERS' COMPENSATION

In California, Workers Compensation **coverage is mandatory,** even if the employer only has one employee. There are of course exemptions such as certain domestic employees, charity or volunteer workers, and certain other workers.

There are 3 ways an employer can obtain Workers Compensation coverage:

1) Obtain Workers Compensation from a private insurer
2) Obtain Workers Compensation from a state fund

Note: The California State Compensation Insurance Fund, which is also referred to as the state fund, is an insurer run by the state. The state fund competes with private insurers within the insurance marketplace, for Workers Compensation business. Sometimes, if someone can't obtain Workers Compensation insurance, they'll go to the state fund as a last resort. Despite that, the state fund is still considered competitive with the private insurers.

3) Self-insurance

Premium determination may be based on the job or job classification. The employer pays total payroll and premiums.

**A. Workers Compensation Benefits**

The types of benefits that are provided under Workers Compensation are:

- **Medical benefits** are provided without limiting the time or dollar amount for all necessary medical/surgical expenses.
- **Income benefits** are provided for employees who've suffered work-related disabilities. There is a **3**-day elimination period, and if the disability continues for **14** days, Workers Compensation benefits are then paid. The benefits are paid retroactively to cover the waiting period as well. For permanent total or temporary total disabilities, the maximum weekly benefit is **66 2/3%** of the worker's weekly income.

- **Death benefits** include burial expenses and these benefits provide income for the surviving dependents in **2** possible ways:
    1) **Lump Sum Burial Allowance**—this method is determined by the number of dependents and how financially dependent they were on the deceased.
    2) **Weekly Income Benefit**—the maximum weekly benefit is **66 2/3%** of the deceased's weekly income.

- **Rehabilitation Benefits**—this method helps to rehabilitate or retrain a disabled person to allow them to return to work as quickly as possible. This could include paying the expense of altering their lifestyle to incorporate the disability, or it could include vocational training, which trains the disabled person for a completely new job.

### B. Workers Compensation Exclusions

The following exclusions apply to Workers Compensation:

- Intentional injuries, either self-inflicted, via prank, or otherwise
- Injuries resulting from intoxication
- Injuries resulting from the employee's failure to use provided safety equipment
- Pain and suffering

### C. 24-Hour Coverage

24-hour coverage is the joint issuance of a workers' compensation policy with a disability insurance policy, health

care service plan contract, or other medical insurance coverage for non-occupational injuries and illnesses.

A life agent is authorized to sell 24-hour coverage and has completed a course, or seminar of an approved continuing education provider, and proctored examination on Workers' Compensation and general principles of employer liability.

## D. Employers Liability

**Employers Liability** protects the employer when injuries are not covered by Workers Compensation. Employers Liability insurance provides coverage for:

- Lawsuits brought by injured employees
- Lawsuits brought by the family/dependents of injured employees
- Legal defense expenses
- Employee's who aren't eligible for Workers Compensation
- Other supplemental benefits

**Exclusions to Employers Liability**:

- Contractual Liability
- Anything that's covered under Workers Compensation, Unemployment Compensation, or Disability
- If the employer intentionally caused the injuries
- If the injury happened outside the boundaries of the US, US territories, or Canada
- If a violation of employment laws caused the damages
- Any lawsuits brought by injured employees who were hired illegally

- Work-related injuries to an employee who was knowingly hired illegally

## E. Common Law Duties

Employer/Employee relationships and employer obligations have changed since the time of the Industrial Revolution. Prior to the enactment of legislation, this relationship was based on common law, that is, case law as handed down by a court resulting from litigation.

Employers had to be negligent and were sued for any injury or death.

The Common Law **Duties** owed to employees included:

- A safe workplace
- Competent and trained workers
- Warning employees of any dangers or hazards
- Safety procedures

## F. Employer Defenses

Employers raised some of the following defenses to prove they aren't liable:

- **Fellow Servant/Employee Rule** states that if one of the injured worker's fellow worker directly caused the injury, then the worker is liable, and not the employer.
- **Contributory Negligence** means if the injured worker was even a tiny bit responsible for the injury, the employer can't be held liable.
- **Assumption of Risk** means that the injured worker knew the rules or the possible dangers, and went ahead and did

it anyway. Therefore, the injured worker is liable for their own injuries.

## 6. Advertising

Each insurance company must establish and maintain a demonstrable system of control over the content, form, presentation, distribution, and dissemination of all such **advertisements** of the policies they offer. All such **advertisements**, regardless who may have produced, created, or disseminated them, remains the responsibility of the insurance company whose policies are being **advertised**.

Alert!
The final exam may ask you who is responsible for the content in a commercial. The answer, as we discussed above, is the insurance company is responsible for the content in the commercial. We're drawing special attention to that point, because the exam wants to make sure you know that inaccurate advertising can't be blamed on anyone other than the company paying for the advertisement.

Advertisements have to be clear and complete in order to avoid outright deception, or unintentional confusion. The Commissioner can decide that an advertisement is misleading. This decision is based on the impression the advertisement is likely to make on any potential buyers.

## ***End of Section***

***When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.***