



## **FIRE & CASUALTY 2009 Supplement**

*Copyright © 2008 D&H Investment Trust*

The California Department of Insurance introduced substantial changes to its prelicense course objectives on November 3, 2008. This supplement highlights these changes.

**IMPORTANT: EXPECT NEW QUESTIONS ON THE STATE LICENSE EXAM STARTING JANUARY 2009. THIS SUPPLEMENT WILL HELP PREPARE YOU. STUDY THIS SUPPLEMENT WITH CARE.**

*This publication is designed to provide authoritative information in regard to the subject matter covered. It is sold with the understanding that the author is not engaged in rendering legal, accounting or other professional services. The information within these pages is general insurance education. It is not to be used to advise your clients or others in specific matters unless we agree in writing, in advance, that it will be used for that purpose. If you need advice for specific client matters, seek a competent professional.*

*For more course offerings  
call (800) 498-5100 or go to:*

**[www.AffordableEducators.com](http://www.AffordableEducators.com)**

**Affordable Educators.Com**  
41890 Enterprise Cir So #100  
Temecula, Ca 92590

# **CONTENTS**

Insurance Companies	3
Licensing	4
Privacy Protection	8
Claims	9
Fire Insurance	11
Flood Insurance	12
Automobile Insurance	12
Homeowner's Insurance	16
Commercial Insurance	19
CGL Policies	22
Health Insurance	29
Long Term Care Insurance	43

# **INSURANCE COMPANIES**

**Fraternal organizations** provide charitable and benevolent activities. Fraternal organizations offer insurance ONLY to their members and beneficiaries and are not for profit. Examples are the Knights of Columbus, Modern Woodmen of America, etc. see 1-6

**Stock Insurers** sell shares of stock to shareholders to raise the money necessary to operate the business. Stockholders receive dividends and share in profits and losses. Policyholders, however, do not, i.e., their policies are ***non-participating***. See 2-10

**Mutual Insurers** are funded by policyholders. They become the owners and receive non-taxable dividends. Mutual company insurance policies are ***participating*** policies. ***Demutualization is a process whereby a mutual insurer becomes a stock company.*** See 2-10

***Paid in capital*** is defined as the value of an insurer's assets in excess of its liabilities, expenses, taxes, debt and reinsurance. See 20-10

**Insolvency.** If an insurer or agency you are involved with is found to be insolvent, the insurance commissioner, without any court order needed, can take possession of books and property. It is a misdemeanor to refuse to deliver any books records or assets once a seizure order has been executed. A violation subjects you to a fine of up to \$1,000 and imprisonment up to one year or BOTH! 20-10

**California Insurance Guarantee Association.** Formed to protect the public from insolvent insurance companies. "Member" insurance companies are required by the State to join. Claims exclude life, annuity, health and disability policies (covered by the California Life & health Insurance Guarantee Association) as well as policies involving mortgage guaranty, fidelity, surety, credit and title insurance. The Association also does not cover any claims already covered by reinsurance. Following are maximum claim amounts allowed by California law: 22-3

<i>Fire &amp; Casualty Claims</i>	<i>up to \$500,000</i>
<i>Workers' Compensation claims</i>	<i>unlimited</i>

## **Surplus Lines Insurers**

An unauthorized insurer isn't allowed to transact normal kinds of insurance, and so they deal with Surplus Lines brokers. A List of Eligible Surplus Lines Insurers (LESLI), can be found on the California Department of Insurance website.

Surplus Lines brokers handle insurance for very high risks and non-standard coverages. 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. The person would then contact a Surplus Lines broker, possibly working through his existing agent, who would arrange insurance through an unauthorized insurer.

It is important to note that there is an absence of “binding authority” when placing business through an excess and surplus lines broker. 20-11

## **LICENSING**

A **Personal Lines Agent** is a person authorized to sell the following insurance: Personal automobile, dwelling and homeowners insurance, including earthquake, flood, umbrella policies and marine insurance covering personal property. He or she cannot sell commercial policies, health insurance, worker’s compensation, or other lines available to a full fire and casualty agent / broker. See 18-2

California requires anyone who **transacts insurance** to have an insurance license. Transact means solicitation of insurance, negotiation and execution of insurance policies and dealing with matters that pertain to and arise subsequent to the execution of an insurance contract. See 18-1

A **Limited-Lines Automobile Agent** is a person **endorsed or appointed** to sell automobile liability coverage, automobile physical damage and automobile collision insurance. It is important to know that a limited lines automobile agent is an **agent license**. As such, these agents **cannot broker** limited lines auto insurance **nor charge broker fees**. See 18-3

A **Surplus Lines Broker** is an insurance producer, **individually licensed** in surplus lines, specially licensed to solicit, negotiate and place insurance with eligible surplus line insurers. NOTE: individuals licensed as a Fire and Casualty Broker-Agent may **not** transact surplus lines business on behalf of a surplus line broker’s organizational license, without also holding an individual surplus line broker. See 18-4

### **Workers Compensation**

In the insurance world, there are workers’ compensation policies sold to employers by agents. In addition, companies can also establish their own self-funded or self-insured workers’ compensation plans for their employees. The terms **aggregate excess and aggregate stop-loss** refer to specially allowed limits on unpredictable losses for **self-insured or self-funded** workers’ compensation plans operated by employers. **THESE FEATURES ARE ONLY FOUND IN SELF-FUNDED PLANS**. As such, it is a misdemeanor for agents to sell, advise or promote the availability of

aggregate excess or aggregate stop-loss features in conventional workers' compensation policies. So, aggregate excess and aggregate stop-loss = self-funded plans ONLY. See 12-3

### **Title 18**

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. 18-5

The insurance code is very specific: **Realtors or mortgage brokers** cannot require their customers to buy insurance as a condition of buying property or closing a loan. Nor, can they require customers to buy insurance through a particular agent or broker. See 18-15

**Display of License:** Your license must be displayed in a prominent place in your office so it may be inspected by anyone to learn that it is current and the right license for the insurance you are selling. See 18-32

**Records:** Agents must maintain records in the principal office in the State of the agent's license and where the insured (customer) is served. Further, records must be maintained in an orderly manner and **readily available and open to inspection** by the insurance commissioner at all times. See 18-32

Records can be manual or mechanical (digital), and must provide an **audit trail** so that details like summary data, invoices, checks and statements can be identified. A record system should be able to trace any transaction back to its original source and sufficiently detail the application or process being performed. The following records must be kept by agents for at least **five years after expiration or cancellation of a policy**: Name of insurer, policy number, effective date, termination date, gross premium amount, net

premium amount, commissions and basis for same, names of others who received commissions or consideration, date premiums received, bank and account where premiums deposited (if any), date a premium was paid or mailed to another person or the insurer, etc. For at least one year after a policy is cancelled, these records must be kept in the office where the insured (customer) was served. For the remainder of the five years, they can be stored off premises as long as they are retrievable in two business days. **Violations** of recordkeeping may cause the insurance commissioner to require the agent to **restore records in 60 days**. Failure to comply can mean suspension or revocation your license. See 18-32

**Agency Name (Fictitious 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. See 18-32

**Internet Advertising:** If you have website advertising for your insurance business, you must be sure to display your name as it appears on your license, your principal place of business address and your license number. You are considered to be **advertising** on the internet if you provide insurance premium quotes, accept applications for coverage and/or communicate with a California resident one or more terms about providing insurance. See 18-33

**Effective Date:** Agents are required to provide ALL applicants for insurance the circumstances (if known) under which coverage will be effective if there are conditions to that coverage. Example: Your insurance will be effective when your premium is received by the insurer. You must notify applicants of their effective date at the time of application or when you provide a receipt for their premium payment. See 18-33

A licensee may **surrender his license** for cancellation by delivery of the license to the Commissioner, or if an insurer holds his license by written notice of the intent to cancel. See 18-11

**Return of premium offsets:** At any given time, an insured may be entitled to a refund or return of premium resulting from a reduction in coverage or cancellation of part or all of his policy. As an agent, you can use this refund to offset or pay for premiums owed on the same policy or another policy . . . as long as the amounts due and refund are for the same insured. See 18-27

**Continuing education requirement changes effective January 2009:**

- Fire and Casualty Agents – A minimum of **24** hours per license term (every two years from date of original license) for agents in business more than 4 years. Under 4 years . . . 25 hours per year for the first 4 years of business, then 24 hours every renewal period (every 2 years).
- Personal Lines Agent -- A minimum of **20** hours per every license period (every two years) following the date of the original license issuance.  
See 18-18

**Pretext Interviews:** The insurance code prohibits the use of pretext interviews to collect information about potential customers. Such an abusive scheme might involve a presentation or group function where potential clients are invited for one purpose (education or entertainment) under the **pretext** of collecting information about the client in order to sell services or insurance products. This is illegal. An example involved living trust mills in the 1990's. Seniors were invited to seminars to learn about the benefits of having a living trust. Information collected at **pretext interviews** was unethically shared or used by licensed agents to learn about client assets that could be repositioned in order to buy annuities or other investment products. See 18-27

**Admitted vs, non-admitted insurer:** For various reasons, you may only be able to place a client's coverage with a non-admitted insurer. A California **admitted insurer** is one that is domiciled (has a license to operate) in California. An admitted insurer is regulated by the State of California and also has the protection of the State's Guaranty Association – a fund used to protect policyholders by paying claims or guaranteeing insurance company investments much like the FDIC protects bank deposits. A **non-admitted insurer** is not subject to solvency and enforcement regulation by the State of California nor are they a member of the State Guaranty Fund. However, these types of insurers may be able to provide special types of insurance, lower rates or more flexible underwriting not provided by admitted companies. See 18-24

**Certificate of Authority** -- All insurance companies in California must have a **certificate of authority**, issued by the Commissioner, to be admitted to transact insurance. It is a **violation** to act as an insurer without a certificate of authority. A public offense punishable **by imprisonment not exceeding one year** or by **fine** not exceeding **\$100,000** or both. See 20-9

You must know the difference between Mutual, Stock and Fraternal insurers and the term de-mutualization. **Stock Companies:** Sell shares of stock to raise money necessary to operate. Stockholders own the company. Policyholders do not participate in dividends. **Mutual Companies:** Policyholders contribute capital and become the owners. Their policies are participating in that they allow policyholders to participate in company profits. **De-mutualization** is the process whereby a mutual insurer

becomes a stock company. **Fraternal organizations** are described as any **benefits society** (without capital stock) conducted solely for the benefit of its members and their beneficiaries and not for profit. See 20-12

**Reciprocal and Risk Retention Group:** A Risk retention Group is a form of insurer owned by policyholders who gather together to “self-insure” all or a portion of their risk, e.g., a group of doctors covering their own claims. In a Reciprocal Group, subscribers or members share insurance responsibilities and losses with other members but are managed by an attorney in fact. USAA is one example. Your consumers should know that coverage through these groups carries certain risks: They may not be subject to all insurance laws; nor do they qualify for state guaranty fund protection. In essence, the ability for these entities to pay claims is based solely on their present or reasonably anticipated financial condition. See 20-16

## **PRIVACY PROTECTION**

**Privacy Protection.** There are several significant acts of legislation affecting the privacy of consumer information provided to financial institutions: See 20-17

- 1. 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.
- 2. 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.
- 3. 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. See 20-17

## **CLAIMS**

### ***Claimant***

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. See 21-7

### ***Proof of claim***

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. See 21-7

### ***File and Record Documentation***

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. See 21-7

### ***Duties upon Receipt of Communications***

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. See 21-8

### ***Standards for Prompt, Fair and Equitable Settlements***

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 See 21-8

**Concurrent clause** is a loss where two perils are involved at the same time and one peril is covered, but the other is excluded. See 4-19

**Microbial Matter Exclusions:** A common exclusion in current personal lines policies is microbial matter (mold, mildew, viruses) which includes fungi and bacterial matter which reproduces through the release of spores. See 4-11

Additional Standards Applicable To Automobile Insurance See 7-40

1. If an insurer is responsible to a third party it is unlawful to recommend the claimant make a claim under his own policy.
2. No shall require or suggest that an automobile be repaired at a specific repair shop unless a referral is requested. Nor, require a claimant to travel an unreasonable distance to have his vehicle inspected, repairs estimated or actual repairs conducted.
3. No insurer shall require the use of non-original parts for automobile repairs unless they are like kind. Nor shall the insurer require a claimant to provide his own parts.
4. If the claimant uses his own repair shop, the insurer cannot limit or discount the reasonable cost of repair.

Repair Shop Recommendation: An insurer can recommend a specific repair shop to repair a claimants automobile as long as the following written notice is provided within 5 days of the recommendation:

"WE ARE PROHIBITED BY LAW FROM REQUIRING THAT REPAIRS BE DONE AT A SPECIFIC AUTOMOTIVE REPAIR DEALER. YOU ARE ENTITLED TO SELECT THE AUTO BODY REPAIR SHOP TO REPAIR DAMAGE COVERED BY US. WE HAVE RECOMMENDED AN AUTOMOTIVE REPAIR DEALER THAT WILL REPAIR YOUR DAMAGED VEHICLE. IF YOU AGREE TO USE OUR RECOMMENDED AUTOMOTIVE REPAIR DEALER, WE WILL CAUSE THE DAMAGED VEHICLE TO BE RESTORED TO ITS CONDITION PRIOR TO THE LOSS AT NO ADDITIONAL COST TO YOU OTHER THAN AS STATED IN THE INSURANCE POLICY OR AS OTHERWISE ALLOWED BY LAW. IF YOU EXPERIENCE A PROBLEM WITH THE REPAIR OF YOUR VEHICLE, PLEASE CONTACT US IMMEDIATELY FOR ASSISTANCE."

## **FIRE INSURANCE**

### **Standard Fire Policy**

New York developed the first Standard Fire Insurance policy during the early 1900s. That policy was used throughout most of the United States, because it was so well designed. This policy became known as the 165-line policy. California made changes to the policy, and created their own California Standard Form Fire Insurance Policy, more commonly known as the Standard Fire policy (SFP). It contains similar provisions to the SFP with the exception that the California SFP coverage, with respect to the peril of fire, is more favorable to the insured. See 4-2

Associated terms you should know include the following:

**Open Policy:** The value of the coverage is not agreed upon, it's left open.

**Valued Policy:** The thing being insured is valued at a specified sum.

**Warranty:** A statement in a policy that imports there is an intention to do or not to do a thing which materially affects the risk. It can relate to the past, present or future. Can be expressed or implied. If it relates to a person or thing insured it is expressed.

**Return of Premium:** An insured is entitled to a return of his premium if the policy is canceled, rejected, surrendered, rescinded or voidable (due to known or unknown fraud or misrepresentation). The return can be whole if the insurer has not been exposed to any risk or proportionate with the unexpired time. See 4-2

**No motor vehicle or homeowner policy may contain a provision that mandates that premiums are fully earned upon the happening of any contingency. See 4-2**

## **FLOOD INSURANCE**

In order to sell flood insurance through the National Flood Insurance Program, FEMA now requires California agents to take a special 3-hour Flood Training Course. See 6-5

### ***Flood Insurance Claim Limitations***

Flood insurance typically excludes the following:

- Damages from normal soil erosion caused by a nearby body of water
- Sewage backup
- Any damages caused by conditions within the insured's control
- Additional living expense and rental value
- Flood caused by war, nuclear reaction, operation of building codes, neglect, fire, windstorm, explosion, erosion, earthquake, landslide or other earth movement. See 6-7

## **AUTOMOBILE INSURANCE**

### ***Personal Auto or Commercial Auto?***

A commercial vehicle is used for the transportation of persons for hire, compensation or profit, or for the transportation of property. Private passenger automobiles are not. RV's (including those as large as 6 wheels) are generally both designed as and used as private passenger vehicles, not commercial vehicles. Once an RV is added to a private auto policy, the existing coverage of the policy is extended to the RV. See 7-2

### ***Auto Policy or ISO Policy?***

ISO (Insurance Services Office) develops standard policy forms for personal and commercial auto insurers. Because these forms are widespread and well known agents need to know how their company's policy differs from the an ISO standardized policy. See 7-2

### ***Auto Policy and Spouses***

As an agent selling personal auto insurance you should know that if one of the spouses leaves the household, they're still covered for up to 90 days, or until they get new coverage, or until the policy expires. See 7-2

### ***Primary, excess and special physical damage:***

Auto insurance coverage follows the ownership of the vehicle first and the driver second. So, if you are an authorized driver of your car and you get in an accident, your insurance is "primary". If someone else was driving your car with your permission, your coverage would still be "primary", the driver's insurance company, however, might be called upon to cover any "excess" or secondary coverage (damages beyond your limits). Certain types of

vehicles, like RV's, snowmobiles, etc may be eligible for ***special physical damage coverage***.

### ***Cancellation of A California Personal Auto Policy***

Regardless of what is said in a policy, the ***Amendatory California Endorsement*** provides a uniform method to handle policy cancellations:

1. Insured's may cancel by returning the policy or giving written notice of the effective date to cease coverage.
2. Insurance companies may cancel a policy by giving written notice showing the cancellation date, the reason for cancellation. If the policy has been in effect for ***60 days or less***, an insurer may cancel for any reason with at least ***10 days notice***. If ***older than 60 days***, a policy may be cancelled with at least ***30 days notice*** for non payment of premium, violation of a law, discovery of fraud, discovery of willful or gross negligence, failure of the insured to exercise reasonable loss control in the event of an accident, a determination by the insurance commissioner that continuation of this policy would threaten the financial solvency of the insurance company or a material change in the insured's activities. See 7-40

### ***Newly Acquired Auto?***

- A. A newly acquired auto will have the broadest coverage provided for any vehicle shown in the Declarations of an existing policy (except collision coverage for damage to your auto).
  - B. Where existing collision coverage is listed, it will begin for the newly acquired auto on the date the insured becomes the owner with notification of 14 days.
  - C. If the insured does not have collision coverage on at least one auto listed in the Declarations page, collision coverage on a newly acquired auto begins on the date the insured becomes the owner, but the insured must request it within 4 days and a \$500 deductible applies.
  - D. If a newly acquired auto is in addition to any vehicle shown in the Declarations, the insured must notify the insurer within 14 days.
- See 7-3

### ***Personal Auto Medical Payments***

With Medical Payments/PIP, the Limit of Liability applies per person. Therefore, if the limit of liability is \$100,000, that means it's \$100,000 per person, not for everyone involved in the accident. Example: "Frank has \$50,000 in PIP coverage. He and his three friends are in an auto accident, and each of their medical bills amounts to \$50,000. How much will Frank's PIP cover?"

- a. \$50,000 only
- b. Frank's injuries only

- c. Everyone's injuries are covered
- d. Frank's injuries are covered first and then whatever is leftover is divided among the other friends

The answer is C. They want to lull you into a Limit of Liability stupor, so remember, in Medical Payments/PIP, it's per person, not per occurrence. See 7-17

Medical Payments have coverage limitations and exclusions. Medical payments, for example, only apply to the insured and his passengers, not third parties. Also, Medical Payments/PIP covers any related expenses that happen within **3** years of the date of the accident. Exclusions include: Vehicles with less than four wheels, vehicles used on private lands/roads (golf cart, maintenance truck, etc.), any vehicle used/designed for racing, a vehicle that's used without the owner's permission, a business vehicle, or a vehicle being used for business purposes, if the primary coverage is Workers Compensation, if the insured is driving a car other than the covered car (hopefully the other car has its own PIP in this situation), war or a nuclear hazard. See 7-18

***Who is insured under UM / UIM:*** Uninsured and underinsured motorist coverage provides coverage for you and all members of your family who reside in your household, passengers, or people driving your car with your permission. A typical limit might read \$100,000 per person / \$300,000 aggregate. So, if the driver of the other car who caused an accident has only \$30,000 per person / \$60,000 aggregate of coverage, you could stand to collect \$70,000 per person from your own UM / UIM policy up to a maximum of \$240,000. See 7-22

### ***Fair Credit Reporting Act***

Your clients must be informed if information in their credit report or other records, such as a Motor Vehicle Reporting detailing driving history, is used to deny an application for insurance. See 7-42

### **Selected Private Auto Insurance Endorsements**

The following endorsements are used to modify a Personal Auto policy:

- **Miscellaneous Type Vehicle Endorsement** allows the policy to cover vehicles with less than **4** wheels, and/or less than **10,000** pounds like motorcycles, dune buggies, golf carts, small mobile homes, etc.
- **Limited Mexico Coverage Endorsement** provides limited excess coverage for autos taken across the Mexico border. Significant limitations apply. For example, the accident must occur within 25 miles of the U.S. border and the duration of the trip must be 10 days or less.

- **Trust Endorsement** specifies that a private passenger auto, pickup or van is deemed to be owned by a person if title is transferred to a Trust. This is handy since a lot of people keep assets in family trusts.
- **Joint Ownership Endorsement** makes coverage available for vehicles which are owned by individuals other than a husband and wife who reside in the same household and for related individuals who live in different households.
- **Auto Loan / Lease Endorsement (GAP Coverage)** pays any amount unpaid due on a lease or loan for the loss of the covered vehicle.
- **Named Nonowner Coverage** gives someone coverage who doesn't own a car, but borrows or rents cars.
- **Extended Nonowner Coverage for Named Individual Endorsement** removes the exclusions for driving nonowned autos that are furnished or available for regular use. This endorsement also removes the business use exclusion that applies to nonowned trucks and vans.
- **Additional Transportation Expenses** increases the usual transportation limits of \$20 per day up to a maximum of \$600, to **\$30** per day up to a maximum of **\$900**.
- **Customizing Equipment Coverage** pays for direct and accidental loss to custom furnishings, special carpeting, special paint or graphics beyond the \$500 coverage typically provided in standard policies.
- **Towing and Labor Coverage** covers the cost and labor associated with towing a damaged car. See 7-33

### **Motorcycle Insurance**

Motorcycles are typically NOT covered by Personal Auto Policies and generally cannot be added as an endorsement. They must be insured on their own and insurance IS REQUIRED by the State of California . . . 15/30/5 . . . a minimum of \$15,000 liability per person, \$30,000 aggregate and \$5,000 property damage. Carrying the minimum, however, may not sufficiently protect your estate, i.e., the decision to increase coverage limits are the same one would make for an automobile, although some motorcycle insurers place limitations on the amount of medical payments and uninsured motorist coverage. If there is a loan on the motorcycle, the lender may also require comprehensive and collision coverage, as well. If the owner does not have health insurance, medical coverage is also desirable. Collision, comprehensive and medical are likely to cost more for motorcycles since the rider and vehicle are more likely to be hurt and damaged in any accident. See 7-31

RV's can be insured on their own or added as an endorsement to most Personal Auto (PAP) policies. Unlike a car, however, there are additional things to consider on an RV like coverage for fixtures, furnishings and appliances. Additional coverage for these items may be available or a

special may be required. And, the type of coverage varies by the type of RV . . . motorhomes are motorized vehicles while fifth wheels and travel trailers are not. There may also be time restrictions on parking and traveling. If the RV is a primary residence then homeowner's type coverage is necessary. ATV's and personal water crafts vehicles (PWC) can be covered by homeowner's insurance. However, coverage can be limited and even non-existent in the case of ATV's ridden off the owner's property. Special coverage is desirable, especially when vehicles are licensed as street legal. See 7-32

## **HOMEOWNER'S INSURANCE**

### **Standard Fire Policies**

The insurance industry has used Standard Fire Policies for years. California has created their own standard fire policy which embraces equivalent or more favorable coverage. The ***purpose*** of standard policy forms is to provide common language that will be similar from state to state. Coverage is typically for loss by fire and lightening on an ***actual cash value basis***. Perils not covered include war, explosion, riot (unless fire ensues), neglect by the insured, theft, vacancy beyond 60 consecutive days, etc. See 4-48

### **Dwelling vs Homeowners Policies**

A ***dwelling policy*** provides coverage for both dwelling and contents on a named perils basis, while a ***homeowners policy*** provides coverage for the dwelling and contents on an all perils basis (a.k.a. all risk), and for the contents on a named perils basis. See 4-47

Why would a structure be insured under a ***dwelling policy instead of a homeowners policy***? Well, if it was a rental unit on your property, it will be covered by a dwelling policy. Homeowners insurance, on the other hand, is suited for those who own and reside in their own home. See 4-47 & 4-48

### ***Homeowner policy form differences.***

The differences in the HO policy forms apply only to the property and personal contents coverage: the liability coverage is the same for all the HO forms. See 4-27

### ***Home Valuations: Loss Settlement Provision***

This provision defines the method that will be used to determine the amount of money the insured will receive for a claim. Usually this provision stipulates that claims will be paid on an ACV or on a replacement basis. This provision also determines how claims will be paid per item, per loss. Items A, B, and C

might be covered on an ACV basis, but items X, Y, and Z are recovered on a replacement basis. See 2-16

### **Actual Cash Value vs Replacement Cost 1-25**

**ACV** is the replacement cost of property minus depreciation. For example, if a television was worth \$350 when you bought it—but that was a few years ago—ACV means you'll receive compensation for the television's depreciated value amount.

**Actual Cash Value Computation:** Determining ACV can be very subjective. Usage, wear and tear, obsolescence, etc are all considerations. And, the definition of "actual cash value" in the policy rules. In general, policies say it is defined as replacement cost, less depreciation. If replacement cost is determined to be \$400,000, depreciation \$99,000 and the deductible is \$1,000 the actual cash value is \$300,000. However, real world situations are not always this black and white.

**Replacement Cost** is the cost of replacing the item. Therefore if the television cost you \$350 when you bought it, the replacement cost would be \$350. In order to qualify for replacement cost coverage, insurers may require an inspection and analysis to determine that a sufficient amount of coverage (and premium) is being purchased. . Where replacement cost is used, the policy limit is usually set for at least 80% of the home's replacement cost, i.e. if you fail to insure a home for at least 80% of the replacement cost, an insurer may assess a penalty.

**Replacement Cost Computation:** If the replacement cost of a home is \$400,000, then coverage must be purchased for at least \$320,000 (\$400,000 X 80%).

When a replacement cost claim is paid, insurers require that the property be repaired or replaced **BEFORE** the full amount is paid. Typically, insurers pay out the actual cash value and hold back the amount attributed to depreciation until this is done.

For additional cost, a higher form of coverage is available through guaranteed or **extended replacement cost insurance**. A **guaranteed policy** will pay whatever it costs to rebuild the home as it was before a disaster, even if it exceeds the policy limits. Extended replacement cost policies pay a certain percentage over the policy limit – typically 20 to 25 percent. 1-25

**Replacement Cost Insurance:** In assessing the valuation of a client's home and the coverage needed, it should be noted the **advice you give** can

affect your client's well being.. For example, recommending the purchase of replacement cost insurance is good, but without optional guaranteed or extended options, complete replacement of the dwelling may not occur. And, while even these additional coverages can provide protection against sudden increases in construction costs due to a shortage of building materials (typical after a major disaster) or rising costs in general, neither routinely cover the cost of upgrading a house to comply with current building codes. An **ordinance or law coverage endorsement** is required here. Also consider that replacement cost coverage may only apply to the residence, not other structures. Under terms of the policy, for instance, a garage may be valued using actual cash value, not replacement cost.

Further, if a lost property was a rental, the loss of rent that results from a disaster may clear limits in the policy. Likewise, liability (bodily injury for example) claims your client incurs as a result of a disaster could have very specific limitations as specified in the declarations page of the policy. So, while replacement cost coverage is advisable, you and your clients need to be aware that gaps can still occur. 1-25

**Earthquake: Single limit vs multiple limit?** Some stand alone earthquake policies have a single limit of coverage, that is, dwelling, other structure, content and loss of use losses would be lumped together into one single limit. Reimbursement, after the deductible, would be made based on a single amount. Homeowner policies with earthquake endorsements are more likely to follow a multiple limit approach where a formula is applied: a dollar amount for the dwelling; 10% of the dwelling amount to other structures; 50% for contents and \$25,000 for loss of use. Add the applicable amounts, less the deductible, to calculate the claim total.

### **California Fair Access (FAIR Plan)**

**Who is the marketplace?** FAIR stands for Fair Access to Insurance Requirements. Most states have their own FAIR Plan, which acts as a safety net for people who may otherwise have trouble getting insurance. See 6-22

**The two areas served?** If someone needs insurance for an insurable property and they've been denied normal insurance coverage, they then become eligible for the FAIR Plan. The fair plan serves **two primary areas: Brush hazard zones and inner-city areas**. See 6-22

**Who qualifies?** In order to obtain insurance through the FAIR Plan, the applicant has to have: See 6-22

- 1) Physically insurable property
- 2) Made attempts to get insurance through normal insurance markets
- 3) Been categorized as a high risk by the normal insurance market

If all **3** conditions apply, then the applicant qualifies for the FAIR Plan. See 6-23

**Who can submit applications to FAIR Plan?** Both personal and commercial risks can be covered in the Plan. However, farm and autos are ineligible. Any licensed agent or broker may submit risks to the FAIR plan. See 6-24

**Meaning of basic property insurance?** Basic Property insurance under the FAIR Plan covering: See 6-23

- Fire and Lightning
- Windstorm
- Riot and civil commotion
- Explosion
- Vehicles
- Smoke
- Hail
- Aircraft
- Vandalism

**Important:** The FAIR Plan covers only “well-maintained” properties. A property with faulty wiring could not be covered. See 6-24

## **COMMERCIAL INSURANCE**

Note: Commercial policies use the following definitions:

“You” means named insured

“Your” refers to only the named insured shown in the declaration

“We”, “us” and “our” refer to the insurer providing insurance 8-1

### **General Commercial Property Conditions**

There are **9** general Commercial property **conditions** you should memorize for the final exam. For the most part, you’ll run into a variation of these conditions in Commercial lines: See 8-10

**1) Concealment and Fraud** applies only to property coverage and states that if the insured intentionally concealed something material or committed fraud, their coverage would be revoked.

**2) Control of Property** means that if someone else committed a negligent act that damaged the insured's property, coverage still applies. Basically, this condition recognizes that the insured doesn't always have control of their property, and mishaps can happen involving other people or situations.

**3) Duplicate Coverage** means that if there is a loss, and there are two or more coverages in the insured's policy that apply to that loss, the insurance company will only pay the amount of the loss. Therefore, if the loss is \$10,000, and it's covered under two different coverages, the insured won't receive \$20,000.

**4) Legal Action** means the insured can sue the insurer within **2** years of the date of the loss if the insured followed all of the conditions of their policy.

**5) Liberalization Clause** means that any policy changes that benefit the insured and don't require a higher premium apply immediately to the policy without the need for endorsements or writing an entirely new policy. The changes have to be made during the policy period or within **45** days of the policy's effective date.

**6) No Benefit to Bailee** means no one else can benefit from insurance other than the insured. This applies if someone leaves their property with a bailee for maintenance or repairs. If the property is damaged, the bailee isn't covered by the insurance, and they'll need to pay for the damages themselves.

**7) Other Insurance** means if the insured has two policies covering the same peril, the companies will each pay a percentage of any losses. The insured can't collect the full amount of the loss twice. Usually, in the event of a loss, if the coverages offer the same limits of liability, the insurers will split the expenses 50/50.

**8) Policy Period and Coverage Territory** means that coverage only applies during the policy's effective date and within the coverage territory (which includes the US, Canada, US territories, and Puerto Rico).

**9) Transfer of Rights of Recovery (Subrogation)** means that the insured can't collect insurance and then go after an at-fault party for damages. They've transferred the right of recovery to the insurance company. 8-10

### **Value Reporting Endorsement Form**

This form provides coverage for a business whose **inventory has fluctuating values** during the year. The amount of insurance is adjusted monthly, quarterly, or annual to reflect the changing monetary value of the inventory. The ability to adjust coverage helps solve the problem of overinsurance as well as underinsurance. 8-10

**Know This:** The Value Reporting Endorsement may be used to modify insurance provided by the **Building and Personal Property Coverage Form**. If required reports of value are not provided to the insurer the most that will be paid in event of loss is **75%**. 8-10

The **Tenancy of Vacancy definition** states that a building is considered vacant if **70%** or more of the **total square footage** in the building isn't being used. 8-13

### Causes of Loss Forms

There are **3** Causes of Loss Forms:

- 1) Basic
- 2) Broad
- 3) Special 8-13

Note: Most exclusions are **included** in the Cause of Loss Form(s).

Note: Other coverages **may not be covered** under all three forms.

Note: **Windstorm** is a covered peril under the Basic, Broad and Special Cause of Loss Form 8-13

### Miscellaneous Forms

The **Business Income with Extra Expense Coverage Form** covers the extra expense of keeping the business up and running **ONLY after a direct physical loss**. There needs to be a complete suspension of operation for the Business Income to be triggered. 8-4

**Remember:** **Business interruption coverage** insurance compensates you for lost income if your company has to vacate premises due to a disaster. **Extra Expense insurance** reimburses your company for money spent, above normal operating expenses, to avoid having to shut down during the restoration period after a disaster. In some cases, extra expense insurance alone may provide sufficient coverage without the need for business interruption coverage. 8-22

**Blanket insurance** is a single dollar amount insurance limit that applies to all insured property, or more than one property, or personal property located at more than one property. This contrasts with **Schedule Insurance** where a list or schedule of buildings and contents with specific amounts of insurance applied to each. **Agreed Value** is when the underwriter agrees with the insured to the amount of insurance and co-insurance. 8-17

**Extended Period of Indemnity** covers a business owner's income over the initial **30** days of coverage. 8-5

Note: Prior to 9/11, **terrorism coverage** was routinely included in commercial insurance policies. Today, most insurers have either drastically raised their premiums or excluded terrorism coverage entirely, BOTH in existing and new policies. The Terrorism Risk Insurance Act of 2002 provides for a sharing of losses between insurers and the federal government. 8-2

### **Builders Risk Coverage**

This form protects property that's under construction. Either the owner or the contractor can be covered by this form. 8-2

The **coinsurance requirement** for Builders forms is **100%** of the completed value of the property. The insured can't ever purchase less insurance than the property's estimated completed worth. 8-2

### **Claims Made Policies versus Occurrence Form Policies**

There are **2** kinds of policies relating to claims:

- 1) **Claims Made Policies** cover claims that are reported during the policy period. If an occurrence took place in an earlier year, the insured is only covered if he/she/they purchased the same insurance year after year.
- 2) **Occurrence Form Policies** cover claims that occurred during the policy term, regardless of when the loss was reported. 2-16

**Note:** A claims-made policy is more flexible. Because a claim has not been made yet, you can increase your limits or buy new coverage that you did not have when you started. Occurrence policies, on the other hand, are more permanent. You are protected forever by the policy you had that year with no need to renew or buy tail coverage.

Here are some associated terms you should know:

**Retroactive Date & Prior Acts:** A policy may be endorsed to cover incidents which occurred prior to the policy start date.

**Tail Coverage:** Coverage for incidents that have not been reported during the policy term.

**Basic Extended Reporting Period:** Begins when the policy period ends. Activated when the policy is cancelled or non-renewed. 2-16

## **CGL POLICIS**

### **Declarations & Limits See 9-2**

The **CGL Declaration Page** lists **six different Limits of Insurance**. Payment of damages on one limit will also affect another limit.

**Aggregate Limits:** The most an insurer will pay during the policy period

**Products-Completed Limit:** Injury and property damage that occur away from the insured's premises from the insured' products or completed work.

**Personal and Advertising Injury Limits:** For offenses arising out of the business of the insured. Personal injury might be wrongly detaining a customer for shoplifting or expelling a customer from premises wrongfully, wrongful entry, copyright infringement, stealing ideas. Advertising injury might apply to defamation, false statements, intrusion of privacy, public disclosure of private facts, misappropriation of a person's likeness or name.

**Each Occurrence limit:** The most an insurer will pay for the sum of ALL damages

**Premises Damage Limit:** Pays for damages by fire to premises rented to the insured.

**Medical Expense Limits:** Pays reasonable medical expenses for bodily injury caused by an accident without regard to fault. 9-2

Here is how these limits might appear in a policy:

<b>ABC Company Limits of Insurance</b>	
\$2,000,000	General Aggregate Limit (Other Than Products-Completed Operations)
\$2,000,000	Products-Completed Operations Aggregate Limit
\$1,000,000	Personal and Advertising Injury Limit—Any One Person or Organization
\$1,000,000	each occurrence limit
\$50,000	Coverage for damage to premises rented to you Limit—Any One Premises
\$5,000	Medical Expense—Any One Person

9-2

### **CGL Insuring Agreements:**

**Coverage A: Bodily Injury and Property Damage Liability**

**Coverage A** covers bodily injury and damages that occur while the insured is conducting his/her business. This coverage applies whether the injuries happened on or off insured premises. 9-7

***Coverage B: Personal Injury and Advertising Injury***

**Coverage B** applies when the insured suffers a personal and/or advertising injury through his/her business. 9-7

***Coverage C Insuring Agreement: Medical Payments*** covers any medical expenses for bodily injuries occurring on the premises, no matter who is at fault. All claims have to happen within coverage territory (US, US territories, Canada), and filed within 1 year of the actual injury date. 9-8

**CGL policy terms** 9-3

- **Who is an “insured”.** An insured, under most CGL policies, means any person qualifying as an Insured under “Who Is Insured” in the Declaration Page, e.g., a director of the company is an Insured while acting within the proper scope of their official duties and powers with the company.
- **Covered Territory** might be defined in the policy as the USA, its territories and possessions, or product coverage worldwide, etc
- **Automobile and mobile equipment.** Very tricky. For example, a truck with a drill mounted on the back might be considered mobile equipment until it is moved. Then it needs to be on the business auto policy. Vehicles that need to be licensed to operate may not be mobile equipment and need to come under your auto policy as well.
- **Leased employee.** Definitions may vary. Some policies say an “employee” includes a “leased worker” but not a temporary worker (someone furnished to meet seasonal or short-term work).
- **Employee.** Whether employees of a company are covered under a CGL policy depends on the relationship to the employer, state law and the policy language.

**Employment Practices Liability**

This is a relatively new type of Professional Liability. It protects the business against the actions of the employees. 9-20

**Note:** CGL policies provide coverage for premises and operations, and specifically excludes professional liability which is coverage for claims based on **professional services fault**. CGL covers losses from bodily injury, property damage, personal injury, or advertising injury that occur from a company’s ordinary activities. 9-18

**Note:** Professional liability coverage defenses differ from CGL defenses in that they are centered around claims against a company's "**professional acts**" through its directors, officers, past or future employees, affiliated companies (names) and even independent contractors under certain situations acting in their capacity . Ordinary acts by employees are excluded, as are acts of intentional dishonesty, fraud or those having criminal or malicious intent. Employment practice liabilities (wrongful termination, harassment, discrimination, etc) are also excluded as are fiduciary liabilities. 9-18

### **Professional Liability Triggers**

The **occurrence policy coverage trigger** is tied to the date of the event or accident giving rise to the claim. The actual claim may arise years after the policy expired. The **claims-made policy coverage trigger** is the date the insured first became aware and notified the insurer of a potential claim. The claim must be made during the policy period, it must be **reported** to the insurer during the policy period, it must have happened after a prior acts or retroactive date and insured must state he had no knowledge of the claim on the date the policy was purchased. Normal policies require reporting during the policy period. **Reporting extensions** can be granted or endorsed. 9-21

**Directors and Officers liability (D&O) Insurance** protects the directors and officers of a company in case they're sued by shareholders, creditors, competitors, and/or stockholders.

### ***Know that there are 3 common D&O insuring agreements:***

Insuring Agreement A: Directors and Officers Individual Coverage

Insuring Agreement B: Company Indemnification Coverage

Insuring Agreement C: Company Securities Claim liability

The **D&O** policy provides coverage for claims made against an **insured while acting as a director or officer**. This coverage has protection for:

- Misrepresentation
- Violation of trust
- Other negligent acts
- Omissions or acts of negligence
- Acts outside their authority
- Failure to perform their duties
- Misstatements
- Wrongful trading
- Reimbursement for expenses as a result of a liability lawsuit filed against them

Exclusions to coverage include:

- Fraud
- Willful violation of the law
- Improper personal profit
- Bodily injury and property damage losses
- Disputes with other directors
- Prior litigation

Protection from ***Employment Practices Liability*** (discrimination, sexual harassment, etc) may require a separate policy or a special endorsement. As an agent advising your client you need to know who is not covered and what losses are excluded. 9-19

### **Commercial Umbrella Policies** 6-19 through 6-21

- A **Commercial Umbrella policy** is a separate policy that extends liability coverage over and above Commercial policy limits.
- There is ***no standard commercial umbrella policy*** although there is an ISO Form. Most insurers, have developed their own form with unique coverage.
- An underlying policy with specific limits is required to be maintained to qualify for a commercial umbrella policy.
- The Umbrella policy can include deductibles or self-insured retention for losses excluded by the primary policy. The difference is that a ***deductible*** is paid to the insurance company when a ***self-insured retention*** is paid directly to the claimant.
- The ***difference between an Umbrella and Excess Liability Policy*** is that the Excess Policy ONLY adds additional liability protection to the limit of the underlying policy without expanding other coverage. For example, if someone has fire insurance and they think they need Excess coverage, they can extend their fire coverage ONLY. If a loss results from another peril, the excess fire liability does nothing.

### **Crime Insurance**

***Important:*** You should know that under some crime insurance policies certain people may not be covered under the policy, including officers, employees and independent contractors. 10-10

### **Boiler & Machinery Insurance (aka Equipment Breakdown Coverage)**

**Why Buy Boiler & Machinery Insurance?** Typical commercial property insurance excludes breakdown of machinery and steam explosions or if covered, pays only AFTER an accident. The premium for boiler and machinery insurance includes an inspection charge to help avoid explosions. Thus, it is proactive. 8-20

## **Commercial Auto**

### **“Who is insured”?**

- The insured
- Anyone using a company car with permission
- Anyone liable for the conduct of the insured 11-6

### **Who isn't covered?**

- Someone driving a family member's or employee's car
- Anyone who works in auto-related businesses
- Non-employees moving property to or from a covered auto
- The people who own the hired or borrowed auto 11-6

**Important:** The *fellow employee exclusion* in commercial auto policies means that an insurer does not have to pay for the losses or injuries of one employee caused by another employee (e.g., bad driving, falling asleep at the wheel, etc) other than to pay the statutory minimum liability coverage required by the State. This liability, say insurers, is more the responsibility of workers compensation insurance. An fellow employee endorsement can be added, however, to provide employee protections not covered by workers compensation. 11-6

**Broadened Named Insured Endorsement** extends commercial auto coverage to the insured's immediate family members. This provides coverage to any family members who may use a non-owned auto similar to **Personal Auto Policy Coverage**. 11-17

## **Federal Government Crop Insurance**

Crop insurance protects against losses to *growing crops*. Crop insurance is *necessary* because most property policies exclude crop damage. How Crop insurance works, is it covers the amount lost, or the **reduced yield**. So, if 80% of a harvest was saleable, Crop insurance would cover the 20% that wasn't saleable.

The Federal Government is involved in crop insurance through the sale of FCIC (Federal Crop Insurance Corporation) (sold through special agents) as well as a reinsurer of policies issued by the private sector.

Note: Crop insurance usually **only covers the harvest**, and not the plants. So, if an apple farmer had Crop insurance, the insurance would cover the apples, not the apple trees. 8-37

### **Commercial Flood Insurance**

A flood is defined by the NFIP as an **excess of water** on land that is normally dry.

Any licensed agent or broker may submit business to the NFIP after taking a special 3-Hour Training Course. 8-37

### **Business Owner Policies**

While Business Owner Policies include more types of coverage than CGL policies, the fixed, **lower limits of liability in a BOP plan** can be insufficient. Larger businesses, or those with special needs should consider added liability insurance as a separate policy to their BOP, or purchase a CGL plan. 8-31

### **Ocean Marine**

**Protection and Indemnity Insurance** is liability insurance written separately or with other coverages. It covers a ship owner against liability. 6-16

**Why is Protection & Indemnity Insurance required?** Simply put, legislation, like those detailed below, exposes boat owner /employer's to added liability which can only be satisfied through additional P&I coverage. In some cases, there are stiff penalties and consequences for failure to obtain this additional coverage:

Under the **Jones Act** a seaman has remedy against his employer if his injury was caused by employer negligence. Workers comp policies typically exclude coverage for work aboard vessels.

Under the **USL&H Act**, an employer's liability can include employee injuries on navigable waters as well as adjoining piers, docks, marine railways or any loading / unloading area.

Under the **Defense Base Act** requires workers compensation coverage for employees working on a military base outside the U.S. or employees working on U.S. sponsored public works projects outside the U.S. 6-16

## Workers' Compensation

**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 through private sources, they'll go to the state fund as a last resort. Despite that, the state fund is still considered competitive with the private insurers. Workers' compensation through the State Fund can be purchased direct or through an agent/broker that has an established business relationship with State Fund. 12-18

There are **4 types** of workers' compensation benefits: 12-4

**Medical benefits** are provided without limiting the time or dollar amount for all necessary medical/surgical expenses.

**Note:** There are *no limits* for Workers Compensation for covered medical benefits either for time or dollar amount. Physical therapy and chiropractic services, however, are now limited to **24 treatments** per claim. 12-4

- **Disability benefits** are provided for employees who've suffered work-related disabilities. 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.
- **Supplemental Job Benefits**—help 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. 12-4

**Experience Modification Rating System** This means an insurer could raise or lower Workers Compensation premiums based on a company's loss experience. If the company has more losses, their premiums may go up. If a company has less losses that are less than what was predicted for the year, their premiums will go down. 12-22

**Exclusions:** Workers' compensation coverage does not cover federal workers' compensation or employer liability issues related to legislation such as the Jones Act, USL&H and the Defense Base Act. (see above or 6-16).

### New Developments

Agents should be reminded that there are ALWAYS new developments in Commercial Lines legislation and laws. Recently, for example, the industry has responded with products and coverage in the following areas: 6-25

**Cyberspace liability insurance:** Covers internet and computer-related losses caused to other parties

**Identity Theft and Restoration:** Provides consumers with the services of a fraud specialist to assist and guide in the process of restoring and protecting stolen identity (some homeowner's policies include this coverage).

**Intellectual Property Insurance:** To protect against the threat of a competitor suing for infringement on ideas or intellectual property. 6-25

## **HEALTH INSURANCE**

**Note:** The California Department of Insurance has jurisdiction over entities that provide coverages designed to pay for health services and expenses UNLESS the health care providers are appropriately licensed or certified by other governmental agencies. 13-1

### **Major Health Insurance Mechanisms**

**A. Indemnity Types** --Insurance companies, Preferred Provider Organization (PPO's), Exclusive Provider Organization (EPO) offering traditional reimbursement of medical expenses. Most health insurance is indemnity in nature.

**B. Consumer Directed Plans** – Health Reimbursement Accounts (HRA), Health Savings Accounts (HSA) and other compatible plans where health insurance is paid for by the employer or self-employed owner.

**C. Self-Funded Plans** – Claims are paid for by the employer up to a point (the stop-loss), thereafter, an insurer pays.

**D. Other Types** – Associations, franchises, trusts, etc. reimburse or pay for member claims under specific terms and limitations 13-9

### Health Terms You Should Know . . .

**Gatekeeper Concept:** A primary care provider or doctor determines the necessity for further treatment by a specialist.

**Accident vs sickness:** Accident refers to sudden unexpected event which causes bodily injury compared to sickness a physical illness or malady.

**Managed care:** A variety of techniques are used to reduce the cost of providing health benefits and improve the quality of care.

**Master policy owner:** A group insurance policy provides coverage to individuals under a single master policy issued to a master policy owner such as an employer, association, labor union, etc 13-9

## Group Coverages

**Individual v. Group Coverage:** In general, individual health plans are **less expensive** than group plans because state laws typically require group plans to accept everyone, regardless of health. Also, group rates are based on claims history of the insured group (a possible small pool of individuals) while individual rates are based on a much larger pool of individuals buying from the same insurer. 13-2

**Group Eligibility:** With Group Health coverage, there may be eligibility requirements (e.g., 1,000 hours in a 12-month period or a waiting period (e.g., you must be employed 90 days before you can be covered). If someone joins the group after the insurance has gone into effect, they will probably have to wait until the end of this probationary period for coverage to begin. 13-4

### **Contributory vs. Noncontributory Plans**

Contributory plans require that employees pay part of the premium for their insurance benefits. This is the familiar paycheck deduction for insurance—something we are all familiar with. It is important to note that at least **75% of eligible employees** must participate in this plan. A non-contributory plan means the employer pays all premiums. The employee pays no part of the premium. 14-14

A **blanket policy** is health insurance covering groups of people such as a group of employees for a certain employer or members of a religious, charitable or civic organization, or members of a union, etc. 14-14

**Occupational vs. Non-occupational** triggers in a policy may determine the degree of exposure and premiums a group health plan pays. For example, a worker at an automobile refinishing shop is exposed to occupational risk when sanding, stripping, buffing or painting a car while at work. A non-occupational risk might be to the owner of the car from the inhalation of paint fumes and other particulates resulting from the work on the car. 13-8

**Third party administration:** A group health plan can be administered by a third party. An example might be the Mayo Clinic providing third party services for a company's group health plan to aid in its design, claims processing, medical management, pharmacy benefit management, customer service, etc. 14-13

**Coordination of benefits:** If a husband and wife both have health plans at their own work, required provisions in the plan must determine who pays for

a claim so the employee receives the maximum benefit without a duplication of payment. 14-16

**Types of Providers and Contracts:** Group plans may have medical services provided through various types of providers such as private and HMO physicians, hospitals, urgent care centers, home health care, etc. Some providers may be on contract to provide services in a PPO (referred provider organization), HMO (health maintenance organization) or EPO (exclusive provider organization) or POS (point of service) type environment. Typically these contracts are agreements whereby the health care provider offers services at a discount.

- **PPO** members choose from a list of doctors and health providers.
- **HMO's** specify the provider you need to use.
- **EPO's** are similar to HMO in that members must stay in the network but they have a choice as to who is their primary doctor.
- **POS** is also similar to the HMO but members are allowed to see doctors outside the network (with certain limitations) at an additional charge. 13-10

### **Group Insurance and The Law: 14-9**

Specific California Insurance Code (CIC) Sections apply to group health policies. You need to know the following:

**CIC 10202** – A “group” is considered two or more employees; employers act as fiduciaries where premiums and coverage is concerned.

**CIC 10203.4** – Group policies may extend coverage to dependents of an employee (spouses, children through age 20 (age 24 if a student)).

**CIC 10200** – Group policies may be issued at “less than usual” or wholesale rates.

**CIC 10206** – Group policies are not contestable (subject to cancellation for misrepresenting information on an application) after two years of being issued, except for non payment of premium.

**CIC 10206.5** – insurers are not responsible or have limited liability for losses due to war, military service or aviation accidents.

**CIC 10208** – an equitable adjustment can be made for any misstatement of age.

**CIC 10209** – employees are entitled to a certificate of coverage stating the protection being provided and that continued and equal coverage is available without insurability upon the employees termination upon payment of applicable premiums and an application by the insured in 31 days.

**CIC 10209** – employees who are entitled, may convert their group plan to an individual plan without evidence of insurability subject to making application and paying premiums.

**CIC 10220** – blanket policies may be issued for a term not exceeding one year

Other legislative issues that affect group policies include the following:

**ERISA** (Employee Retirement Income Security Act) – Private and union plans are protected where those managing the plan are considered fiduciaries with specific responsibilities under the law.

**COBRA** (Consolidated Omnibus Budget Reconciliation Act) – Provides former employees, retirees, spouses and dependent children temporary continuation of health coverage at group rates if the employee is terminate. Applies to companies with 20 employees or more.

**Cal-COBRA** – California health coverage legislation requiring employers with 2 to 19 employees to provide them and their dependents the right to continue health coverage after a qualifying event.

**FMLA** (Families and Medical Leave Act) and **ADA** (Americans with Disabilities Act) – Both required a covered employer group plans to grant medical leave to an employee in certain circumstances, e.g., pregnancy, serious health condition, dependent care, etc. ADA prohibits discrimination against a person regarded as having a disability. FMLA applies to companies of 50 employees or more. ADA applies to companies of 15 employees or more.

**HIPPA** (Health Insurance Portability and Accountability Act of 1996) – Imposes privacy requirements on health plans. Portability provisions prohibit plans from discriminating against enrollees on the basis of health status. 14-9

### **Other Health Related Insurance**

Within the insurance industry there are also many limited lines of insurance where agents can dabble or specialize: 14-20

- **Travel accident** – covers travelers, employees, families of employees for anything from trip cancellation, loss of baggage, medical emergencies, accidental death, repatriation and more.
- **Dread disease and critical illness** – coverage for debilitating, but not necessarily deadly diseases like cancer, Alzheimers, Parkinsons, etc
- **Hospital income and confinement** – pays a benefit (income) while the insured is in the hospital
- **Accident only** – pays benefits when the insured and/or family members have accidents

- **Credit and credit life** – pays the balance of a loan when the insured dies or becomes disabled
- **Blanket** – allows a single policy to cover more than one type of property at the same location, or multiple properties at different location owned by the same insured.
- **Health** – covers the high cost of medical expenses (probably the most valuable coverage when you consider one incident, like a heart attach with complications, can run millions).
- **Dental** – typically covers a portion of the bills for dental services . . . many paid for by employers.
- **Vision** – partial or full coverage for eye examinations, glasses, contact lenses . . . with and without copays.
- **Prescription Drug Card** – insurance to pay for all or a portion of the insured’s prescription drugs. Or, allows them to purchase them at a discount.
- **Supplemental Accident** – pays for out-of-pocket expenses related to accidental injury that an existing health plan does not cover.

It is important to note that limited lines insurance policies, like those above, have the possibility of **limited benefits**, such as:

- Policies that provide for expenses incurred for an accident or disease **ONLY**.
- Policies that pay a **fixed dollar amounts** for diseases or impairments
- Policies that provide benefits for specified **limited services**.
- Policies that indemnify on a fixed dollar amount **per day**. 18-6

### **A Final word on health and disability insurance**

As an agent, you should be able to identify other sources of coverage that should be considered when determining a family’s health or disability insurance needs, e.g., the need for workers compensation, social security, Medicare, work-related benefits, etc. When one considers the high cost of a health-related incident can be in the millions, health and disability coverage might be considered the most valuable protection you can provide. If you market yourself as an “expert” in healthcare insurance, you might be considered negligent for not exploring and recommending other widely available coverages. 14-20

### **Other Types of Health Plan Funding**

In addition to the traditional forms of coverage health and disability care policies and providers, individuals, employees and the self-employed have

options to fund routine or supplemental health expenses using the following plans:

**Medical and Health Savings Account (HSA, MSA)** – tax advantaged savings accounts can be combined with high deductible health insurance to pay for uncovered or supplemental health expenses.

**Flexible Spending Account (FSA)** – tax-advantaged payments from an employee are administered by an employer to provide a health care fund to pay for medical expenses not covered by the employee's traditional health policy.

**Health Reimbursement Account (HRA)** – tax-advantaged programs that allow an employer to reimburse and deduct medical expenses incurred by his employees.

**High Deductible Health Plan (HDHP) & HSA** – health plans for individuals, employees and self-employed with higher than normal deductibles. The strategy is to team the HDHP with an HSA. The money saved by choosing a high deductible plan can go into the HSA and pay for some of the deductible costs as well as routine medical expenses.

**Consumer Driven Health Plan (CDHP)** – consumers use some form of HSA, HRA or FSA to pay for routine medical care while a HDHP protects them from catastrophic expenses they might incur in a hospital stay or accident.

### **Eligibility and Ratings**

As an agent, it is your responsibility to identify how your client's circumstances, eligibility and/or ratings affect his ability to obtain health insurance as well as available options. Following are factors to consider:

**Demographics** (gender, age, occupation) – while employers cannot discriminate by sex or age, insurers can. For example, women and older individuals / employees, who statistically use more health care, may cost more to insure.

**Industry** – health care costs and benefits may vary based on the associated industry risk, e.g., a health care worker is at a higher risk of illness than a secretary.

**Location** – areas of higher density are likely to incur higher accidents and health care costs than rural locations.

**Carrier history** – certain carriers accept certain health risks and reject others. Knowing their standards and history can save the time and frustration that comes when a client is rejected, especially if he was not acceptable from the start.

**Medical history** – knowing your clients chronic or ongoing conditions, catastrophic illnesses, pregnancies, disabilities, dependents and extended benefits from a former carrier are essential to him obtaining correct

coverage, affording needed coverage or even being eligible for coverage at all.

**Contribution** – some policies, like workers compensation, are non-contributing (the insured does not need to contribute or pay in order to be covered).

**Participation** – coverage may only be available if the insured is an employee, member, officer or a dependent of same. 14-21

## **HICAP**

In California, HICAP (Health Insurance Counseling and Advocacy Program), through its volunteers, provides unbiased information to help Medicare beneficiaries and their families make the best choices for their health care. Education on Medicare, long-term care and Medicare-related coverage (Medigap, Medicare Advantage, etc) is their primary role, along with legal help at any Medicare appeals and administrative hearings. Services are free and counselors do not sell insurance products. HICAP is sponsored by the California Department of Aging. Counseling is available in every California County by calling (800) 434-0222 or find locations at [www.calmedicare.org](http://www.calmedicare.org). 16-4

## **DISABILITY INCOME INSURANCE**

### **Need For**

A disability income policy provides an insured with a portion of their earnings if they become disabled. A lot of people tend to overlook this type of policy, but statistics show that today's working force has a 50% chance (or higher) of being disabled for more than three months before they reach retirement. 15-1

### **Partial vs Total Disability**

**Partial Disability** means the person can't perform one or more of their regular duties. Usually a partial disability lasts from 3-6 months. The person usually receives 50% of the total disability benefit for a partial disability.

**Total Disability** means the employee—due to work-related injury or disease—will never be able to return to his/her normal job. 15-2

Social Security has the most stringent definition of total disability. That being the "inability to work at any substantial gainful occupation". Others might say "inability to perform duties for which the insured is reasonably suited", or inability to engage in his own occupation". 15-2

## **Occupational vs. Non-Occupational Policies**

Disability income policies may be occupational or non-occupational. **Occupational** coverage provides payment for disability arising out of accidents occurring on or off the job. **Non-occupational** coverage pays ONLY for disability that is not work-related. Group health plans typically do not include occupational coverage because that is covered by workers compensation insurance. An occupational policy pays benefits whether or not the disability is covered under workers' comp. A non-occupational policy does not pay if workers comp pays. 15-2

### **Disability Income Subject To Income Tax?**

If the insured pays for premiums (as in an **individual policy**) then the premiums aren't tax-deductible, and any future benefits aren't considered taxable income.

If an employer pays the premiums (as in a **group plan**) and the insured receives benefits from the plan, then the employer can deduct the premium payments from their taxes.

In a **franchise plan**, a disability income insurer is contracted for and negotiated by the employer, association or labor union on behalf of its employees or members, but each employee or member negotiates and contracts for his or her own individual policy, i.e., several policies are issued, one to each employee or member. Rates and benefits vary. If the cost is carried by the employer, the benefits are taxed. 15-11

### **Limitations on Coverage?**

Insurers will limit the amount of disability income benefits a person can apply for based on age, earnings and other policies in force. The reason benefits are designed to be lower than an insured's normal income (say 60% of routine earnings) is to discourage people from abusing coverage and becoming dependent on benefits for long periods of time. 15-6

### **Types of Disability Income Policies**

**Individual Policies** are typically sold to professionals or the self-employed. The benefit amount is intended to replace as much after-tax income as possible when a disability prevents the insured from earning a living.

**Business Overhead Expense Policies** are sold to business owners to cover **business overhead expenses** in case the owner suffers a disability. Rent and utilities might be paid, but NOT loss of income, inventory or cost of capital.

***Business Disability Buyout Insurance*** provides funds to purchase the interests of an owner or partial owner of business should they become disabled.

***Group Disability Income Insurance*** provides coverage for employees, managers, officers, partners, associates, etc. The purpose is to provide individual disability income benefits within a group contract.

***Key Employee and Partner Policies*** are not as common as buyouts. Nonetheless, the loss to a business when a key player or partner becomes disabled and unable to work can be the same as if the person died. This form of disability income protects the business from this loss exposure with benefits of between 40 to 70 percent of the disabled person's income.

### **Eligibility and Rating**

Eligibility and ratings affect policy premiums and coverage. All are influenced by the following factors:

***Age*** – A younger person is actually more likely to incur a job-related disability than an older person. On the other hand, older workers are more likely to be in poor health. The length of time a benefit lasts may be reduced for an older employee. Underwriters assess all factors in determination eligibility and rates.

***Gender*** – Men are more likely to be injured on the job, but women have more health issues.

***Income and elimination periods*** – A higher salaried person is more likely to survive a longer elimination period.

***Job Classification*** – Occupation has a direct link to the cost of disability income coverage. Riskier jobs have a higher incidence of disabilities affecting both eligibility and premiums.

***History*** – Medical history BOTH on and off the job are important to know. Someone with a preexisting condition might be more likely to be disabled and therefore likely to pay more or be rejected.

***Avocation*** – A person with a high risk hobby is more likely to end up disabled.

***Waiting periods*** – A longer waiting period before benefits begin means a lower premium. People able to financially survive longer waiting periods will get better deals.

***Probationary Periods*** – The day the policy goes into effect tends to be longer for longer term benefit plans. The benefit of having a choice here is that it allows an insured to purchase a benefit that fits their needs. 15-13

### **Disability Income Policy Provisions and Riders 15-15**

***Maximum and minimum benefits*** – benefits for an insured are based on a maximum or minimum wage, e.g., a benefit can be no more than 70% of

your earned income, or 90% of the weekly average wage, or a minimum of 45% of the weekly average wage.

**Notice of claim** – a claim must be given to the insurer within a specified number of days from when it occurred, e.g., 20 days.

**Automatic increase** – benefit payments automatically increase each year based on a set schedule, e.g., 5% per year for the first 5 years.

**Beneficiary** – who benefits are payable to.

**Own occupation** -- if the insured's disability keeps them from performing their job, they can collect disability.

**Cost of living rider** – higher benefits will be paid as the cost of living increases. No proof needed that your income is higher.

**Benefit period** – example: pays benefits up to 50% of earned the insured's wage; payable for a maximum of 5 years

**Social Security benefit rider** – additional benefits can be paid if the insured does not qualify for Social Security disability benefits.

Benefit integration – all the insured's sources of income are factored. Coverage can be reduced if other sources exist.

**Residual** – a person can return to work but a residual condition keeps the person from performing all of their usual duties, which reduces the person's income.

**Rehabilitation** – Additional benefits, beyond monthly income, are made to cover vocational rehabilitation.

**Recurring disability** – no additional benefits are paid unless the reoccurring disability is determined to be a new disability.

**Transplants** – If an insured donates an organ and it results in a disability benefits may be reduced or limited.

**Standard exclusions** – like most disability income plans, the policy contains certain standard exclusions like waiting periods, reductions, limitations, terms, etc.

**Return of premium** – requires the insurer to refund a portion of the insured's premiums if no claims are made for a specified period of time state din the policy. 15-15

## **MEDICARE**

**Eligibility** - To be eligible for Medicare, an individual must: 16-4

- Be over age 65
- Be a Social Security Disability Insurance (SSDI) beneficiary who has a medical determination of disability by Social Security
- Be under age 65 with EndStage Renal Disease (ESRD).

**MEDICARE SERVICES** are provided through several program products.

**Original Medicare** – Part A, Part B, etc (see below) where doctors submit bills direct to Medicare of patient services. There are no limitations on the doctors one can use.

**Medicare Advantage** – Medicare beneficiaries have the option to receive Medicare treatment through private plans of many types. The private insurers receive a set amount each month from Medicare for each patient and must provide equivalent or better service. Services can be provided through *HMO or PPO* groups where the doctors one can see are limited or specific. Many are operated on a ***managed care basis*** where the gatekeeper system helps reduce costs. A *private fee for service plan* allows one to choose doctors he wants as long as the doctor agrees to the Medicare payment terms. A *special needs plan* for those who qualify for both Medicare and Medi-Cal; a *demonstration plan* for chronic and serious medical conditions and

**Medicare Part D Prescription Drug Plans** – Coverage is ***optional***, but available to anyone eligible for original Medicare Part and Part B or any Medicare-approved private plan. There is a separate monthly premium (about \$25/mo), annual deductibles (about \$300) and co-pays (about 25% up to \$2,500 in drugs). It covers brand-name and generic prescription drugs at participating pharmacies. The idea is to lower the cost of prescription drugs, but people in the program may have monthly premiums, deductibles and/or pay a portion of prescription costs.

## **Medicare Part A Terms To Know 16-6**

***Inpatient coverage*** -- pays for any usual and reasonable charges that are incurred while hospitalized.

***Benefit period*** -- begins when the patient is admitted, and ends **60 days** after discharge.

***Deductible:*** For 2009, the Part A deductible is \$1,068. This is paid when the beneficiary (patient) is admitted to a hospital. This is the **ONLY** cost he pays for up to 60 days of care. An additional \$267 deductible ***per day*** is paid for days 61 through 90 and \$534 ***per day*** beyond 90 days.

***Co-payments:*** From the **61<sup>st</sup>** day to the **90<sup>th</sup>** 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.

## **Medicare Part B 16-8**

Medicare Part B is designed as an optional and supplemental insurance to Part A. Anyone enrolled in Part A can enroll in Part B by paying a monthly premium.

**Part B** requires a small annual **deductible** (about \$140) and the following **co-payments**:

- 20% of all reasonable charges for medically necessary services
- The cost of the first three pints of blood used in medical procedures

Enrollment in Part B can be delayed if a person's employer's coverage is still considered "primary".

**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

### **Medicare Enrollment 16-14**

There are 4 ways to enroll in Medicare:

**Initial Enrollment Period (IEP)** – when one turns 65 he may enroll 3 months before or after his birthday.

**Annual Enrollment Period (AEP)** – anyone age 65 or older can also enroll between Nov 15 and Dec 31 of each year for coverage effective January 1.

**Open Enrollment Period (OEP)** – between Jan 1 to Mar 31 of each year one can switch to a different Medicare plan, e.g., you can switch to Medicare Advantage from Original Medicare or visa versa.

**Special Enrollment Period (SEP)** – available anytime if one forgot to sign up and has been covered by a group medical plan since turning age 65

### **Medicare Claims Under the Original Medicare Plan 16-14**

**Submitting Claims** – Individuals do not need to file claims. As long as they are enrolled as Medicare service providers, doctors or hospitals, submit all claims.

**Medicare Assignments** – an "assigned claim" is one that is submitted and paid by Medicare. A "non-assigned" claim is paid by the beneficiary and later reimbursed by Medicare directly.

**Contracted Medicare Providers and Suppliers** – doctors and hospitals contracted with Medicare who are **required** to submit claims on your behalf.

**Medicare Summary Notice** – a summary of claims (covered and not covered) processed for an individual in the past 3 months. These notices are mailed direct to beneficiaries.

**Exclusions** – claims that are not reasonable or necessary may not be paid.

## **Medicare Supplements, aka Medigap Plans**

Medigap plans are supplemental health insurance plans sold to Medicare eligible beneficiaries. They provide coverage for medical expenses that are not covered or only partially covered by Medicare. There are many Medicare Supplement plans which have been designated A through L. The **National Association of Insurance Commissioners** (NAIC) recently adopted a standard model for Medicare Supplements that add **K and L** plans. Their purpose is to reduce the over-utilization of “first dollar” coverage as an incentive to help beneficiaries control costs, i.e., if individuals know they have to pay a deductible or co-pay, they may forgo seeking medical treatment for minor issues that can typically be self-treated. The NAIC model also suggests a revision to H, I and J plans to eliminate prescription drug coverage for those enrolled in Medicare Part D. 16-12

**Medicare Select** is a version of Medigap insurance. The difference is that Medicare Select plans operate on a preferred provider basis where insurance companies list participating doctors and hospitals from which the insured must pick in order to receive benefits. This usually means lower premiums than other Medigap policies. NAIC standard guidelines for Medicare Select plans are met if the service network has been contracted with the insurer; special and urgent services can be met outside the network; there is sufficient access to a network; and the insurer has made some arrangements for quality assurance of the network. 16-12

### **Medicare Supplement - Agent World Rules 16-13**

If you are planning to sell Medicare Supplement Policies, you should be aware there are numerous California State Insurance Codes that apply to the soliciting, enrollment, issuance and replacement of these policies . . . CIC 10192 through 10194. Following are important highlights:

**10192.8** – preexisting conditions cannot be excluded for more than 6 months; sickness and accident losses are considered one and the same; all policies are considered guaranteed renewable and noncancelable (except for nonpayment of premium) without regard to health status.

**10192.10** – a policy shall not be advertised as a “Medicare Select Plan” unless it has contracted with providers to establish responsibilities as well as alternative or discount pricing or provide certain advantages; there is reasonable access to the network; there is a system of quality assurance; if not reasonable to get to a network provider (as in an emergency) outside services are covered; a system for complaints and appeals is established.

**10192.11 & 10192.12** – a person who is 65 years or older can't be denied Medicare supplement insurance or receive different treatment due to a preexisting condition or medical condition for 6 months after they've enrolled.

**10192.16** – agent commissions for selling policies shall be spread over 5 years minimum with the first year commission being no more than 200% of the second year (high first year commissions might encourage unnecessary replacement or churning).

**10192.20** – prohibits twisting of facts or high pressure techniques to induce a person to cancel an existing policy in order to buy another of the same or lesser value.

### **Medi-Cal 16-16**

Medi-Cal (also known as Medicaid in other states) is a welfare health insurance program for individuals who live well below the poverty line. Medi-cal covers most health care costs, including:

- Hospital bills
- Physician bills
- Nursing home care

Although it is a federally created program, it is administered by individual states, and the eligibility requirements vary by state. Eligibility usually requires:

- Qualification for public assistance or welfare
- Qualification for Supplemental Security Income (a program for impoverished people who are over **65 years of age**, blind or disabled in some way).

Generally, those eligible for **Medic-cal** include:

- Low-income individuals over the age of 65
- Low-income individuals under the age of 21
- The blind and other disabled persons
- Low-income families with dependent children

## **LONG TERM CARE INSURANCE**

### **Why is Long Term Care Insurance Needed? 16-18**

LTC issues have made consumers more aware of the importance of this type of policy. Many people are not eligible for Medi-Cal and Medicare and Social Security do not cover LTC. The statistics are a wake-up call:

- **1** in **4** people over **65** will spend some time in a nursing home

- **1 in 3** people over **85** will spend some time in a nursing home.

The average cost for nursing home care (**LTC**) is approximately between **\$4000** and **\$6000** a month, and these costs continue to grow.

### Legal Definition 16-17

The State of California determines that you are legally selling long term care insurance if the policy you are marketing includes:

- Coverage for diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services that are **not** provided in a setting other than an acute care unit of a hospital.
- Products containing coverage for **institutional care** (nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing facility or personal care home); **home care** coverage (home health care, personal care, homemaker services, hospice or respite care).
- Long-term disability care, but not policies designed to cover Medicare supplement or major medical expense coverage.

### Types of benefits 16-17

Generally, when discussing **LTC**, we mean long-term institutional care (nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing facility or personal care home) as well as **home care** coverage (home health care, personal care, homemaker services, hospice or respite care).

### Levels of LTC Care 16-21

There are different levels regarding the type of **LTC** one receives and what a policy will cover:

- **Intermediate care**, which means nursing and rehabilitative care is occasionally required.
- **Skilled nursing care**, which means nursing and rehabilitative care is required daily.
- **Home health care** are services performed in the person's home (nursing, household concerns, help with **ADL's**).
- **Adult day care** is a service for anyone who works during the day but also cares for an elderly relative. Adult day care provides company,

supervision, and recreational support during the day for those who live at home but need assistance.

- **Custodial care** is help with **ADL's** that can be provided by an individual without specialized medical training or skills.
- **Respite Care** gives family members who are looking after elderly relatives a break from care-giving.
- **Hospice Care** is provided at the home or at a care facility for terminally ill people, usually who have 6 months or less to live.

Note: Custodial care is the most common level of care, and it's also the type of care Medicare doesn't cover.

### **Benefit Triggers 16-20**

This is the beginning of the benefit process under an **LTC** policy. These "triggers", as follows, are defined by federal law:

- The inability to perform a minimum of two activities of daily living (**ADL's**).
- Cognitive impairment or loss of abstract reasoning that requires supervision or assistance. This includes Alzheimer's and other mental dysfunctions with medical causes

### **Evaluating Policies 16-22**

The following provisions are commonly included in LTC policies:

***Youngest and oldest ages*** -- this specifies when **LTC** policies may be purchased, with the minimum usually around 55 and the upper age range between 69-89. However, **LTC** policies are currently being sold to people much younger than 50.

***Renewability*** -- most **LTC** policies are guaranteed to be renewable and cannot be cancelled except by failure to pay the premium

***Premiums*** -- the younger the individual at the time of purchase, the lower the premium. Most **LTC** policies have a level, premium that cannot be raised individually. Premiums depend on age when purchased, amount of benefits, level of care covered.

***Waiver of premiums*** -- After **90 days** (may be longer, depending on the policy), policies may include a waiver of premium after the insured is receiving care

Note: **Prior hospitalization** is no longer required for **LTC** benefits to be paid.

**Care level** -- this refers to what benefits the policy will pay towards custodial, skilled nursing, or intermediate care when entering a nursing home.

**Respite care** -- This will cover the cost of replacing a primary caregiver for a short period, usually a day or a weekend.

**Home health care** -- Most **LTC** policies cover this type of care as an alternative to nursing homes.

**Adult day care** -- The day care may be provided in the home for an elderly person while the primary caregiver, usually a relative, works.

**Benefit amount** -- This refers to the maximum daily benefit for nursing home care or home health care. Higher daily benefits mean higher premiums.

**Benefit periods** -- This refers to the maximum period for which benefits will be paid, usually from **3 to 5** years. Some policies have unlimited benefit periods.

**Preexisting conditions** -- This is a determining factor in the type of **LTC** policy an individual purchases. Some don't cover preexisting conditions that existed **6 months** before the effective date of the policy.

**Exclusions** -- These depend on the type of policy purchased. Most exclusions include acts of war, alcohol or drug abuse, mental illness or self-inflicted injuries.

**Inflation protection** -- Some **LTC** policies include automatic percentage increases in benefits every year or an opportunity to purchase higher benefit levels for a higher premium.

**Elimination period** -- The period after the onset of a loss and benefits are not paid. The longer the waiting period, the lower the premium.

### **Suitability Standards 16-25**

California law (SB 1052) introduced an entire insurance code devoted to **client suitability standards**. Insurance companies must immediately develop and train agents in the use of suitability standards and make them available to the Insurance Commissioner. In determining client suitability for

long term care insurance or replacement/conversion of same, the agent and insurer shall consider the following:

- 1) The ability to pay (**affordability**) for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
- 2) The applicant's **goals or needs** with respect to long term care and the advantages and disadvantages of insurance to meet these goals or needs;
- 3) The **value**, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

### **Marketing Standards and Responsibilities 16-25**

LTC Agents must know some very specific responsibilities in order sell this valuable insurance:

**10234.93** -- To solicit or sell long term care policies in California, agents must take an **8-hour certification course** where many stringent laws, guidelines, suitability issues and disclosures require diligence and compliance. New agents (in business for less than 4 years) must repeat this course every year for the first 4 years in business. Senior agents (more than 4 years in business) must repeat this course every renewal period (every 2 years).

Agents must also provide prospective applicants for LTC insurance a copy of the long term care **shoppers guide** (California Department of Aging) as well as the number of **HICAP** (Health Insurance Counseling and Advocacy Program) at (800) 434-0222 where applicants can receive free advice on their LTC choices.

**10234.8** – Agents and insurers of LTC owe policyholders and applicants a duty of honesty and duty of good faith and fair dealing.

**10237.1 and 10237.5** – A prospective LTC policyholder must be given the option to purchase **inflation protection** where benefit levels can keep pace with anticipated increases in the cost of long term care at not less than 5 percent compounded annually. A **special form** is required to be signed by any applicant who rejects this inflation protection.

### **Consumer Protection 16-27**

**10234.85** – Agents shall not cause a policyholder to replace his long term care insurance policy unnecessarily, especially if it will result in decreased benefits and increased premiums. **Unnecessary** is a 3<sup>rd</sup> policy sold to a policyholder within any 12-month period.

**10234.9** – Advertising designed to produce leads must prominently disclose “an insurance agent will contact you” if that is the case. “**Cold lead**” advertising (methods to disguise the real purpose) must also disclose their purpose is to sell long term care insurance.

**10234.97** -- In **any replacement situation**, keep in mind that agent **commissions are limited** to the difference between replacement and original coverage so long as the insurer declares that a “material improvement” in policy benefits has taken place. Commission or compensation includes remuneration of any kind, including, but not limited to bonuses, gifts, prizes, awards and finder’s fees.

### **Qualified vs. Non-Tax Qualified LTC Policies 16-20**

**Tax Qualified Policies** -- Intended to be federally qualified long term care contracts must comply with **IRS 97-31 definitions** and provide that the **chronically ill** insured qualifies for benefits if there is:

- 1) Impairment in two out of six activities (ambulating is now added to TQ policies in California) of daily living expected to last at least 90 days
- 2) Impairment of cognitive ability needing substantial supervision

**Non-Tax Qualified Policies** -- In every long term care policy or certificate that is NOT intended to be federally qualified the insured must qualify for benefits if either of the following criteria are satisfied:

- 1) Impairment in **two of seven** activities of daily living .
- 2) Impairment of cognitive ability.

### **California Partnership for Long Term Care 16-26**

California is also one of many states that has introduced **partnership** programs between the state and private insurance carriers. The goal of the California Partnership for Long Term Care program is to find a workable solution to the problem of financial impoverishment that happens when long term care expenses hit low-to-middle income families. In addition to traditional long term care benefits, these policies usually carry an **asset protection feature** that assures the beneficiary that he or she will keep a certain amount of assets and STILL qualify for Medicaid or Medi-Cal programs.