NAILBA

The Voice of Independent Brokerage Distribution

2010

Brokerage Desk Reference

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FOREWORD

This educational resource is sponsored by the National Association of Independent Life Brokerage Agencies (NAILBA) and is intended to be used by employees of NAILBA member agencies.

NAILBA was organized by independent agency managers and owners who wanted to work collectively to accomplish certain objectives, including the following:

- To foster and expand responsible distribution of life insurance, health insurance and other related financial services for the benefit of the consumers, agents, and companies served by independent brokerage agencies.

- To increase the knowledge of efficient and profitable applications of technology and systems among independent brokerage agencies' management.

- To provide a means of handling common concerns with collective efforts.

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NAILBA STATEMENT OF RESPONSIBILITIES

- To hold in high esteem the distribution of life insurance through independent life insurance brokerage agencies in recognition that this method of distribution provides consumers with a greater degree of choice.
- To maintain and improve the prestige of the independent life brokerage distribution system and to act in a manner which will bring honor to independent life insurance brokerage agencies.
- To respect the confidentiality of records we handle as we provide our services.
- To present accurately, honestly, and completely every fact essential for our brokers in their efforts to serve clients.
- To study constantly and to perfect our knowledge of our products and services.
- To conduct business on an ethical level to bring honor to our industry and our agencies.
- To abide by both the spirit and the letter of the laws and regulations governing the insurance industry.
- To treat our fellow practitioners in the life insurance brokerage business with the respect they deserve and to encourage a spirit of cooperation and mutual respect.
- To represent our companies in a moral and responsible manner, providing them with all of the pertinent information available to us necessary for underwriting.
- To be mindful that it is the consumer, the insurance buyer, whom we serve through our brokers.

WELCOME

Welcome to your new career!

Although you may be new to the Brokerage Industry, you are already a part of the very special community that is Brokerage. We perform our job through teamwork and through the special talents and functions of each person on staff. Because we work as a team, each person's contribution is critical to getting the entire job done well. As such, each and every member of the team, regardless of job title or responsibility, is important.

As with most kinds of businesses, we have our own special "world" of products, services, procedures, and terminology. You'll be continuously learning about each of these. In fact, people who have been involved with the life insurance brokerage business for 20 or 30 years are still regularly learning about new insurance products and policy provisions are offered by life insurance companies. Many of these changes are a result of the competition that exists within the insurance industry. Offering new products and serving new markets is an important part of what we do.

This book will help you begin the process of learning about brokerage general agencies and what we do.

WHAT IS A BROKERAGE GENERAL AGENCY (BGA)?

A brokerage general agency (BGA) is an organization that helps insurance salespersons, or agents, find and obtain specialized life insurance coverage for their clients.

Specialized coverage can mean many different things. For example, it may mean helping a life insurance agent obtain a policy for a person who had heart surgery two years ago and can't get a policy through traditional channels.

Or perhaps it refers to someone who wants an unusual kind of policy, one that the agent doesn't have available through his primary life insurance company. This happens frequently in competitive situations in which one agent wants to match or out-do the offer of another agent.

Another example of specialized coverage is a scenario in which an insurance agent has an extremely complex business insurance situation that requires special, technical assistance.

These are just a few examples of the types of specialized needs that might be taken care of by a brokerage house, or brokerage general agency.

Before we proceed in describing how brokerage houses operate, let's first take a look at how a typical life insurance policy comes into being.

A TYPICAL LIFE INSURANCE TRANSACTION

In simple terms, the standard process for buying a life insurance policy develops as follows:

1. A person makes a decision to buy life insurance.

Because people tend to be uncomfortable talking about death, and few know how to go about assessing their life insurance needs or what kind of coverage to buy, it is generally uncommon for the average customer to initiate the process of buying life insurance. Instead, it is the life insurance agent who makes proactive contact with the client and, through a needs-assessment process, it is the agent who determines the client's needs will point out the value of life insurance as a means of meeting those needs.

2. The prospective client applies for a life insurance policy.

Once the life insurance needs assessment is complete, the prospective client applies for a life insurance policy. This is done by submitting to the life insurance agent a written application and sometimes a portion of, or the entire, initial premium. In some cases, the amount of the initial premium may exceed the insurance company's "binding limits," so money will not be accepted until the company thoroughly examines the case.

3. The agent submits a completed life insurance application to his home office.

Typically the agent submits the policy application to the local agency office of that company. For example, an agent of the ABC Life Insurance Company would present the completed application to the local office of the ABC Life Insurance Company for forwarding to the home office of the ABC Life Insurance Company for processing. After considering the information given about the proposed insured on the life insurance application, the home office will issue the policy and send it to the agent.

An important side point to mention here is that the insurance company home office, or main office, does more than just consider the information on the application. It also underwrites the application.

In simple terms, the main office carefully examines and evaluates the information on the application and compares it with existing statistical averages (mortality tables) to see how it measures up in terms of being a normal, standard risk for insurance purposes.

Often, the home office asks that applicants complete a medical examination and additional medical requirements to determine the appropriate risk factors. If a full medical examination by a physician is not needed, the agent may be asked to set up a paramedical examination, conducted by a specially trained nurse. This process also involves investigating the credit rating of the proposed policy owner, as well as any activities that may increase the risk to the company, such as skydiving or scuba diving. In addition, the life insurance company will likely investigate the applicant's reputation, current job-related information and other relevant details regarding his current financial situation. Upon completion, the price of the policy issued will be based on where the risk lies with relation to a standard risk.

Not all policies that are applied for are issued, and if they are, they may not be issued at standard premiums. In fact, a portion of the business of brokerage houses comes from applications rejected or rated by the agent's primary company. A rated policy is one that is priced at a higher than normal premium because it is a higher than normal risk. Once the decision has been made, the process continues as follows:

- The agent delivers the policy to the new policy owner.
- If the policy owner has not yet paid for the insurance, he will pay the first premium upon delivery.
- The agent will report to the agency that the policy has been delivered, and will turn in any signed amendments plus any premiums collected.

In summary, life insurance is typically purchased through a process involving four parties:

1. The applicant (the person who wants to buy life insurance)
2. The life insurance agent (the salesperson)
3. The local office of the life insurance company
4. The life insurance company home office.

WHY COME TO A BROKERAGE HOUSE?

As we've pointed out, this four-party process isn't always successful. For a variety of reasons, the agent's primary life insurance company or companies can't always handle the insurance needs of the agent's clients. When this happens, the agent needs to have a few alternative insurance companies available.

First, the agent might assume that obtaining the needed insurance coverage is going to be impossible, or too troublesome or too time-consuming, and the agent might therefore drop the case entirely, leaving the client with no additional insurance.

In many cases, a lack of expertise or experience in this area may cause an agent to think, "What if I can't get anything better?" This could be due to a lack of confidence in, or general lack of knowledge of, the alternatives, or even an agent who is not familiar with brokerage houses.

It's possible, too, that the terms of the agent's contract prevent him from doing business with other companies. If, at this point, the agent decides not to pursue insurance coverage for the client, then the client will be faced with a choice: stop pursuing the insurance coverage or find another agent who knows how to handle this specialized coverage.

Also, the agent may choose to shop around from company to company to find one or more that is willing to provide the needed coverage. Although this is something that can indeed be done by the agent, it is generally a time-consuming and cumbersome process. It involves not only finding companies that handle this type of insurance situation, but also researching the companies' reputations to determine if they provide prompt personal service, have adequate support staff, and are financially sound and stable. This research process also requires the agent make phone calls to the home office, establishing contact with the right people, and trying quickly to build rapport and confidence.

Questions about procedures and how to complete the application are typical, so the agent might have to call the home office several times and get clarification of the procedures and administrative details. This long process can be costly for the agent and unprofitable for the company. Agents who submit only occasional business are generally very expensive for companies to do business with.

Therefore, the agent might turn to a brokerage general agency in hopes that it will be able to find a solution to the client's needs.

Brokerage houses are, by definition, organizations that handle special situations or special markets, or special needs. For this reason, the agents who do business with them are likely to be repeat customers. And, since the brokerage house wants repeat business from the agents it works with, it will do what it can to make the entire process as simple, easy, efficient, and as pleasant as possible for the agent.

Brokerage houses represent several different insurance companies and are accustomed to receiving business from a large number of agents, including some who produce only occasional business. They are equipped and staffed to provide quality service in these situations, and want repeat business from all their agents.

Agents represent a wide variety of special marketing interests and job categories, the most common of which include:

- Career agents—Career agents work solely for one life insurance company under an exclusive contract. Some companies are more restrictive in their contract than other companies.
- Independent agents—Independent agents work principally for more than one life insurance company.
- Primary company plus brokerage agency—Some agents work both with a primary company and a brokerage agency.
- Property and Casualty (P&C) agents—Property and casualty agents primarily sell insurance such as auto and homeowners coverage. However, some of these agencies employ life insurance agents who, in addition to P&C policies, also sell life insurance. Life insurance agents working in this environment must be sensitive to the fact that they may be selling to clients who purchased P&C coverage from another agent and are thereby already generating commission for the original agent and agency.
- Personal Producing General Agents (PPGA)—PPGA agents are, in a sense, their own managers, working solely for several life insurance companies. They have the authority to appoint sub-agents. An integral and important part of their duties is personally selling life insurance.
- General Agents (GA)—General Agents work for only one company and have the authority to appoint sub-agents. The general agent's contract may or may not call for him to personally sell life insurance, and most of the GA's time is devoted to recruiting, training, and managing agents and office staff.

4-3 Why Come to a Brokerage House?

When an agent engages in business with a brokerage house, the process of submitting the case is the same as outlined above, with brokerage house simply taking the place of the local agency. Four parties are commonly involved in the process:

1. The applicant (the person who wants to buy life insurance)
2. The life insurance agent (the salesperson)
3. The life brokerage agency (brokerage house)
4. The life insurance company home office.

When working with a brokerage house for the first time, agents are encouraged to proceed with caution until become familiar with the companies' procedures.

An important distinction should be noted: Life insurance company home offices are the originators of life insurance policies. Brokerage houses often resemble small home offices, but in most cases, they don't actually issue the life insurance policies.

In a sense, brokerage houses are similar to wholesalers who handle the products of several manufacturers. Most brokerage general agencies do business with 10 to 20 home offices they've hand-picked because the home offices have a good reputation, or because they represent one or more of the brokerage house's specialty areas.

A brokerage house can work efficiently to place a life insurance application with the right insurance company by using, in many cases, just one preliminary inquiry form for all companies the agency represents. A preliminary inquiry form ("informal") is a trial application that is used to get a quick indication of acceptability from a home office with cases that carry an unusual risk. Many insurance companies today prefer and accept only a complete formal life insurance application from prospective clients. However, whether formal or informal, the application typically needs only one set of attending physician statements.

Knowing the insurance companies' preferences, the brokerage house can be wise and prudent in submitting a case to the appropriate company or companies to ensure the agent receives the best quote possible.

For example, unlike the individual agent, the brokerage house deals with many home offices every day and is familiar with their operations. A partnership built on trust already exists between the brokerage general agent and the companies they represent.

The brokerage house also knows what specialties are handled best by its core of companies; information that would not be easily accessible to the agent. The brokerage house, therefore, doesn't have to guess or spend time and resources to investigate them.

Additionally, unlike the agent, the brokerage house handles numerous cases day in and day out. This extensive experience provides them with a unique ability to make a good assessment of the various companies' underwriting action, and to appraise a case in advance to determine what, if any, additional information will be required by the insurance company to assess the case. For example, if the home office is likely to request extra medical examinations, additional blood studies or X-rays, or an expansion of medical histories, the brokerage general agency can proactively order these requirements in advance to improve efficiency. By anticipating what a home office will need, the brokerage house saves time by providing the underwriter with a complete file the first time around.

When the file is complete, the life brokerage agency submits the file to the appropriate company or companies. In special cases, this selection of insurance companies may have been preceded by a telephone discussion in which the company expressed an interest in handling the case.

By submitting the case only to appropriate and interested insurance company home offices, the brokerage house avoids the hassle of wasting the time and resources of an insurance company, thus protecting the reputation of the agent. As we noted earlier, no company can be profitable if they continue doing business with an agent who submits each special case to several home offices. No company wants to handle 25 cases to write one.

ISSUING POLICIES: WHAT THE HOME OFFICE DOES

For any relationship to work well over the long haul, each party must know the needs of the other party and respond to them as efficiently as possible. This certainly holds true in the partnership between brokerage agencies and home offices. To do their jobs well, brokerage house personnel must understand the needs of the home office underwriters who will be making judgments and decisions about the fate of the file before them. Underwriting varies from company to company. That is one reason why a brokerage house represents multiple companies.

The case file will contain some, or all, of the following items:

- The application for insurance
- The attending physician's statement (APS)
- A credit report (also known as an inspection report)
- A letter from the agent explaining the history of the case
- Other medical findings or reports
- Additional items of information or clarification from the brokerage house

The home office underwriting department is where a case gets evaluated and where a decision is made about issuing a policy. The department's bottom-line questions are:

- Will we issue this case?
- On what basis will we issue it?
- If we will not issue the policy as requested, will we consider issuing a modified policy?

Underwriting departments use a combination of statistics and judgment to determine whether or not to issue a case and on what basis. Arriving at these decisions is a complex process which takes into account the applicant's current health, health history, age, occupation, credit record, hazardous activity in which he is involved in, and other relevant information that helps the home office underwriters compare the applicant with standard risks.

Making "right" decisions is very important to the home office. The company needs to underwrite aggressively enough to attract new business yet conservatively enough to maintain appropriate profitability for the insurance company. It can take many years to discover if underwriting decisions have been too liberal or too conservative, so striking an appropriate balance is critical to the company's success.

CONCERN FOR THE AGENT

The attitude of the brokerage general agency toward the agent is based on more than just attracting and satisfying the agent in order to make a profit for the brokerage house. The fact is, a great deal hangs in the balance for the agent. If the brokerage house performs well with this particular transaction, the agent reaps the benefits of having provided good service to a client, and the agent is likely to return to the brokerage house to transact future business. It also increases the likelihood that the agent will refer other brokers to the agency. Such referrals are very important to the brokerage house.

However, if the brokerage house does not perform well, the agent is likely to be dissatisfied and will probably not do business with that brokerage house again.

Consider the fact that an application submitted by an agent is most likely the result of weeks, months, and sometimes even years of work by the agent in cultivating a relationship of trust and confidence with the prospective new policy owner. In addition to satisfying the client with this particular transaction, the agent has an eye on future business, as well.

For example, will this particular person continue as a client in the future? Will he buy additional insurance from the agent? Will the client recommend the agent to others, who will in turn buy insurance over the years? Future purchases by the client and by the client's referrals could mean considerable income to an agent who is paid on commission.

With this in mind, it is the job of the brokerage house to make sure that nothing under its control causes a rift in the relationship between the agent and his client. As part of the brokerage house team, you are that agent's support staff. Your performance, good or bad, will play an important role in affecting how the agent is perceived by his clients. Your willingness to take initiative may be the difference between the agent closing the deal or not getting paid at all.

At the end of the day, selling insurance is hard work. Not only are the long hours and mental strain physically demanding, but there is an emotional price to pay due in no small part to the rejection the agent experiences as many people say no to his suggestions and proposals. Out of respect, the brokerage house has a responsibility to carry out its job in a conscientious manner. **The support staff of any agency or home office works for the agent.**

TRUSTWORTHINESS IN RELATIONSHIPS

A brokerage house has a responsibility to carry out its job in a conscientious manner, with a commitment to integrity and service. Because a brokerage general agency deals with extremely confidential information about both the agent and the agent's clients, it is imperative to maintain a relationship of confidentiality. Trust is a critical factor in securing an agent's repeat business.

Keep in mind, also, that agents do business with brokerage houses by choice, and there are many choices out there. To differentiate itself from the competition and to keep the agent coming back, the brokerage house must deliver its services more efficiently than any other distribution system, and with extraordinary discretion. We must earn an agent's business on every case he submits.

The brokerage house remains sensitive to the needs of the agents who are our customers, the home office personnel who are our suppliers, and the end client who is buying the life insurance coverage

To be effective, however, this conscientious relationship must be mutual. Just as the agent has spent time in building a relationship with his client, the brokerage house has also dedicated many years to cultivating the partnership between its companies and producers. This relationship is a brokerage agencies most important resource.

It is for this reason that the brokerage house requests sensitivity from its customers and suppliers in return. This symbiotic relationship must be kept in mind with each transaction you perform and each contact you have.

QUALITIES TO BRING TO THE JOB

Sensitivity. Conscientiousness. Confidentiality. As you've read on the preceding pages, each of these is an important element of any job within a brokerage agency. With those in mind, there are a number of personal qualities and traits that will help you to succeed in your position, including:

- **Desire to be of service**—The most important job of a brokerage agency is to help the agents who come to us for assistance. Your desire to assist others is fundamental to carrying out your job, and will reflect itself in a positive attitude.

- **Desire to learn**—Ours is an ever-changing business operating within an ever-changing industry. Flexibility and the capacity to view change as an opportunity to learn, expand your expertise and to be of service to our clients will serve you well in your career.

- **Determination and patience**—Carrying a life insurance case through to a successful completion can be a lengthy process, yet it is absolutely critical to our operations. Some cases are more difficult than others, requiring strong determination, fortitude and patience to see them through to the end.

- **Pride in a job well done**—Finding gratification in a job well done is personally rewarding and can be the motivating factor that challenges us to do continually do our best.

- **Self-starter**—If you can proactively see and know what needs to be done, then do it, you will play a crucial role in helping our company become even more efficient, reputable and profitable.

- **Integrity**—Brokerage houses must earn the trust and confidence of the agents and the companies we deal with in order to succeed. Treating each and every client with integrity is especially vital as we strive to build and develop trust and confidence one transaction at a time.

- **Cooperative**— You are an integral part of our team with each case you handle. The key ingredient of effective teamwork is each individual member's cooperative attitude. This may mean setting aside some of your own goals, replacing them instead with the greater goal of the team.

USING THE TELEPHONE

Most of your contact with agents and home offices will be by telephone. For that reason, your telephone manner is a key factor in forging a relationship of trust and mutual respect. In this section we will discuss some of the personal qualities that will help you effectively and efficiently use the telephone for conducting business. Then we will delve into some specific techniques for its use.

Qualities to Bring to the Telephone

- **Ability to Ask Questions**—Confidently asking questions is the only way to ensure you understand the agent's situation and needs. The same is true in your dealings with a home office. Whether on the phone or in person, asking appropriate questions can be the quickest way to get the information you need to effectively do your job. If you're unsure about something or want to clarify a point, just ask. It's important not to guess when the answer could be as simple as a telephone call away. Don't worry about bothering the agent, or appearing to not know what you are doing. Asking questions shows people you want to do your job well.

- **Ability to Listen**—Listening is critical to understanding. Likewise, understanding is critical to providing good service to our producers and to being responsive to the needs of our home offices contacts.

- **Empathy**—As we have mentioned repeatedly throughout this book, the most important function of a brokerage house is to be of service to the agents who come to us for their insurance needs. The best way we can be of service is to understand and appreciate the agent's situation, perspective, and needs. Empathy is just that: mentally and emotionally being able to put ourselves in another person's situation. This is symbolic of the individualized attention we provide our agents and companies.

- **Thick Skin**—Sometimes things can be said by a client or contact at the home office that really hit a tender spot with us. Naturally, there is a temptation to react in a defensive manner. Resist the temptation to do so in every instance. Not only can defensive reactions portray a lack of personal professionalism, they can endanger the important relationship the brokerage agency strives to maintain with its agents and insurance companies. Adopt some intellectual mechanism that will let you respond civilly to challenging or offensive situations. An effective way to do this is through self-talk. For example, you might simply tell yourself that you are being paid to be understanding. That, plus a dose of self-discipline, will help you control how you respond in moments of anger.

Techniques to Use on the Telephone

Chances are you have already mastered the personality traits that will aid you in using the phone to do your job. If you hadn't, you probably wouldn't be reading this manual as a new employee! This section outlines a number of very basic, but helpful telephone etiquette techniques that will help you in your daily job function, including:

- Speak directly into the mouthpiece.
- Identify yourself immediately.
- Check the volume, speed, and clarity of your voice. For example, if a caller asks you to repeat something, it may be an indication you are speaking too softly, too quickly, or too indistinctly.
- Allow yourself to pause. If you want to stress a point, pause after you have said it. If the other person is taking notes of something you say, you should anticipate the time it takes and pause when you think it is appropriate. Or simply ask, "If you're taking notes, let me know if I'm going too fast."
- Be positive. Try to avoid negative words such as "We don't," or "I can't." Instead say, "Here's what we can do for you."
- Try to let the caller hang up first. Not only is this polite, it also gives the caller a final chance to ask a question or add a comment.
- Be careful not to make promises that could create unrealistic expectations. Reliability, rather than out of reach promises, gives you the credibility you seek.
- Take your time, don't be hurried. Take as much time as you need to get, or give, the information you require, and to be sure it is accurately received.
- Avoid distractions. Don't let others in the office distract you. If someone insists on talking to you, excuse yourself, place the call on hold, and return to the call as soon as possible. Express your regrets to the caller and continue.
- Develop your listening skills.
- Give the caller your full attention.

- Don't interrupt unless it is important to do so. Also, a pause doesn't always mean that the other person has finished saying everything he wanted to say.

- Make interjections. An occasional "yes," or "I see," shows the agent or home office employee you are still with him and that you understand what is being said.

- Listen for overtones. Quite often, the tone of someone's voice will tell you things that the words don't.

- Take notes. This allows you to wait to interject a comment or ask a question and helps you keep the details of the conversation in perspective.

CUSTOMER SERVICE

Customer service is a broad concept that affects several, if not all, aspects of your job. Included in it are such diverse factors as your knowledge of the company's products, your ability to interact with others, your organizational skills, your empathy, your initiative and your determination. By now you realize that the most important job of our brokerage agency is to help the agents who come to us for assistance. This is an ongoing commitment; we promise service and we keep our promise.

Service begins with the initial inquiry an agent makes to us. This service continues as an application is submitted and processed, and as a policy is issued and delivered to the agent. This all happens in a concentrated time frame.

Our commitment to service does not end after the policy has been issued. Rather, you may receive from time to time other requests from the agent that require additional service. Each transaction involves completion of a particular form supplied by the home office of the company that issued the policy, and the procedures for handling these transactions vary from one brokerage house to another.

Your supervisor will be able to assist you in managing and following up on these situations when they arise. However, it is helpful to be aware of the types of scenarios that may present themselves. Some common requests include:

- Change of Beneficiary—Requests for change of beneficiary are made for a variety of reasons. Death of the existing beneficiary and marriage or remarriage of the insured are two common reasons for wanting to change the beneficiary.

- Change of Name—Changing the name of the insured on a policy is typically requested when the person has married and is changing her surname to that of her husband. In such cases, it is common to change the name of the beneficiary for the same reason.

- Transfer of Ownership—Requests for change of ownership of a policy are often made by parents who want to turn over control of a dependent's life insurance policy once the child is over the age of 21. Another situation involving change of ownership of a policy occurs when the current owner seeks to make a charitable contribution of the policy to, say, a religious or educational organization. Ownership sometimes changes with policies used for business purposes, as well.

- Lost Policy—A lost policy request is commonly made when a policy owner realizes that a policy has been lost or misplaced.

- **Surrender**—This request is made when a policy owner has decided that he no longer wants the life insurance policy and is requesting to be paid any and all cash values that may have accumulated in the policy.

- **Decrease or Increase of the Face Amount**—A policy owner may ask to decrease the face amount of a life insurance policy in an attempt to lower the premium amount or in cases when he feels he no longer needs the current amount of coverage. If the policy owner seeks an increase in the face amount of the policy, he will be required to submit current evidence of insurability. Typically this means completing another application for insurance.

- **Change of Mode of Premium Payment**—Most policy owners pay for their insurance either monthly, quarterly, semi-annually, or annually. One other variation is the automatic deduction plan, wherein a bank automatically deducts the monthly premium from the insured's checking account. As their financial circumstances change, policy owners may decide to change the frequency of their premium payments.

  An important note about automatic deduction payments: If you receive a request from a policy holder who has been making premium payments via automatic deduction, but who now wants to change to another mode of payment, **you must get the request in writing** before you can process the change The reason behind this requirement is simple: If the policy later lapses for nonpayment of premium and the insured person dies, the heirs can legitimately claim that, as far as they know, no change of premium payment had been requested. In such a scenario, the family of the insured can claim it was a mistake on the part of the insurance agency that caused the policy to lapse, and therefore insist that the full death benefit be paid.

- **Reinstatement of a Lapsed Policy**—Quite often, after a policy has lapsed for nonpayment of premium, the policy owner will seek to have the policy reinstated. Depending on several factors, including the time that has passed since the policy lapsed, the home office may require new proof of insurability. This may simply be completion of a short application, or it could involve another physical examination. In some instances, policy holders are required only to pay the back premium.

- **Death Claims**—In some cases, the agency may serve as a liaison between the agent and the home office when an insured person dies.

OVERVIEW OF INSURANCE COVERAGES

In the following chapters, you'll discover the components of a life insurance policy, typical policy provisions, and some of the current types of policies, beginning with the basics. We will repeat the process with disability income insurance policies, group insurance coverage, and annuities.

LIFE INSURANCE POLICIES AND PROVISIONS

This section will focus on policy provisions, different kinds of life insurance policies, and recognizing policy differences. Most life insurance policies offer information in a similar manner. For example:

- All policies have a title page that gives a quick representation of the key facts of the policy, including a summary of the plan, the premium, name of the insured, the policy owner, beneficiary, policy date, and how long premiums are payable.

- Most policies contain a Table of Contents of the policy.

- A copy of the application is required by law to be attached to the policy and is part of the binding contract.

- Policy provisions are common to nearly all policies and are relatively uniform from company to company. Once you become familiar with the most common policy provisions, it will be easier to work among insurers.

Every life insurance policy has the following participants, who may represent six different parties:

1. The insurer (The life insurance company)

2. Insured

3. Owner

4. Applicant

5. Beneficiary (The "person" named in the policy to receive funds that will be paid when the insured dies. The beneficiary may be an individual, a trust, the estate of the insured, a charitable organization, or the spouse or children of the insured, among others).

6. Premium payer.

Following are definitions and descriptions of common terminology that will help you better understand the process of writing a policy and the language commonly used so doing:

- Life Insurance—A succinct and uniform definition of life insurance is difficult to name. It can be viewed in many ways from a variety of perspectives, and often encompasses a numerous optional elements. For example, a congressional definition of life insurance exists for purposes of income taxation. An attorney might define life insurance in terms of a contract, perhaps even a unilateral, contract of adhesion.

  On the other hand, a beneficiary may see life insurance simply as money needed to help sustain the surviving members of a family, or to see a business through a critical period after a key person has died.

  From a strictly academic perspective, the dictionary defines life insurance as a voluntary method by which many people join together in a cooperative venture by contributing to a common fund, so that a stipulated sum of money will be paid at the death of any one of them. Suffice it to say, a whole book could be written about the definition of life insurance alone.

- Rate Quotes/Rate Making—Rates for life insurance are generally quoted per $1,000 worth of insurance or premium rates. They can vary widely depending on many factors, such as the elements of the plan of insurance, the age of the applicant, as well as factors such as the health and occupation of the applicant. An additional policy fee may also be required in some cases, as well as fees for optional benefits or riders.

- Home office actuaries—These individuals, skilled mathematicians, are assigned the task of determining what the rate is for that $1,000 worth of insurance. Actuaries take several factors into consideration in establishing life insurance premium rates, including mortality rates, interest rates and expenses. Mortality rates essentially show the frequency of death at each age among a defined group of people.

Policy Provisions

The following are descriptions of and comments about certain policy provisions and riders that are most likely to be of practical help to you. Descriptions of most other policy provisions and riders are included in the Glossary section later in this text.

- **Insured**—A life insurance policy is purchased to assure a specified sum of money at the death of a named individual, the insured. Various factors are evaluated in determining whether or not insurance will be issued and, if so, at what price.

  In order for a policy to be issued, an insurable interest must exist at the time the policy is issued. Essentially, this means the insured must be worth more, or mean more, alive than dead to the beneficiary.

  Insurable interest can arise in two ways: (1) love and affection from a close relationship with the beneficiary by blood or marriage; or (2) a lawful economic interest in having the life of the insured continued, or an economic interest where the death of the insured would cause a financial loss to the beneficiary.

  Thus, a spouse has a "love and affection" insurable interest in a spouse, a parent, or in a child. A business has an economic insurable interest in the continued longevity of a key employee whose death would mean a loss of profits. A charity would have an economic interest in a supporter whose continued life would likely mean the receipt of monetary contributions or other valuable services. However, the insurable interest may come into question in cases where, say, a friend or cousin is named as the beneficiary. Such an example may not meet the company's insurable interest criteria unless some other overriding relationship exists.

  Normally, one insurance policy insures one individual. In some cases, though, insurance is purchased to protect against the loss of more than one person, or one of several persons. For example, a joint life policy covering a husband and wife would pay the face amount at the first death to occur. In a survivorship policy, the death benefit would be paid at the death of the second insured. If separate death benefits are not needed at each death, multiple-insured policies can yield premium savings. A group insurance policy might insure the lives of all employees under one policy, with individual certificates being given to all employees to show they are indeed insured under the group policy.

- **Owner**—It is the owner of a life insurance policy who is entitled to exercise the policy rights and privileges. While the owner is typically the insured person, there are many examples in which this is not the case, particularly with regard to insurance used in business situations. Other scenarios in which the owner will be different from the insured include policies purchased by parents for minor children and some marital situations in which insurance is used for estate planning purposes.

  The policy owner retains the right to assign the policy, change the beneficiary, change the owner, and surrender the policy. Other owner-specific rights may also include borrowing against the policy, changing the plan of insurance, and selecting a settlement option, that is, the method of payment elected when the death benefit of the policy is paid out to the beneficiaries. The owner's rights can be exercised only during the insured's lifetime. Upon the death of the insured, the owner no longer has any rights or privileges. Such rights are vested instead to the beneficiary.

  If ownership has changed since issuance of the policy, the name of the new owner will typically appear on a separate endorsement page. Sometimes the name of the original owner will be "stamped over" with a notice that a change has been made, and is reflected on the endorsement page.

- **Beneficiary**—In many ways, the beneficiary selection is the most important aspect of an insurance policy. It embodies both the purpose of the insurance and the reason the policy is purchased. The importance of naming a beneficiary or beneficiaries has many similarities to the importance of naming beneficiaries in a Will or in a trust. It is an area where the motives and intentions of the policy owner must be made specific, not only for the primary or direct beneficiaries, but also for other categories of contingent beneficiaries.

- **Incontestability**—Once the policy is issued and has been in force for two years, the life insurance company cannot contest the policy. This assures the beneficiary and the insured that no claim will be denied on the grounds of any misrepresentation that may have occurred at the time of purchase. Over the years, court decisions have broadened the written promise so that today, even if there was intent to defraud, frequently the company will be required to pay. To best protect their interests, life insurance companies will follow stringent procedures in evaluating what risks are insurable, and at what price.

- **Right to Examine Policy**—Many states provide that the owner has the right to return a policy for any reason within 10 days after receiving it. A policy so returned will be considered void from the beginning, and any premium paid will be refunded. The actual number of days varies by state, but the concept is the same: Insurance is an important purchase, and the owner retains the right to be sure of what he or she is doing. This "free-look" provision can help solidify the reason for purchase and verify what was, in fact, purchased.

- **Nonforfeiture Provisions**—The level premium concept inherent in permanent life insurance, which will be discussed later, gives rise to "reserves," or policy owner's equity in a policy. A portion of each premium is ear-marked to pay death benefits to beneficiaries. These reserves belong to the company as long as it has the obligation to pay death benefits. However, guaranteed cash values are accumulated and available to the policy owner if he decides to cancel the agreement. These cash values can also be borrowed by the policy owner at an agreed-upon rate. Payment of interest on the loan is required by the policy owner, however, because the mathematical assumptions underlying the policy's values presuppose they are invested and earning interest.

  The policy owner has the right to stop premium payments and take the reserve values in one of three ways: (1) In cash; (2) As extended term insurance; or (3) As reduced paid-up insurance.

  A proposal for insurance will reflect some of these values so the policy owner will have an idea of the options available at various points in the future, and a table is included in the policy showing the guaranteed values on a year-to-year basis.

  If "cash" is chosen, the policy owner can take the surrendered cash value in a lump sum, or ask to be paid a fixed income over a specified period of time. Paid-up insurance is a reduced amount of insurance that will stay in force with no more premiums. Generally this sort of policy will have some cash value still available. On the other hand, extended term insurance denotes the original amount of insurance, still kept in force for the period of time specified, but with cash value no longer available.

  The table on page 11-6 shows an example in which, after 15 years, a policy owner could stop paying premiums and have the following options:

  1. Surrender the policy for its cash value of $26,900; or
  2. Elect $51,400 of paid-up life insurance; or
  3. Elect $100,000 of extended term insurance that would continue for the next 20 years and 65 days

$100,000 Face Amount
Table of Guaranteed Values

END OF POLICY YEAR	CASH OR LOAN VALUE	REDUCED PAID-UP INSURANCE	EXTENDED TERM INSURANCE YEARS	DAYS
1	$ 140	$ 300	0	152
2	1,740	4,500	4	182
3	3,380	8,600	8	65
4	5,060	12,500	10	344
5	6,760	16,400	12	260
6	8,790	20,700	14	335
7	10,840	25,000	16	147
8	12,930	29,100	17	207
9	15,040	33,000	18	177
10	17,190	36,900	19	78
11	19,080	40,000	19	209
12	20,990	43,000	19	306
13	22,940	45,900	20	8
14	24,900	48,700	20	47
15	26,900	51,400	20	65
16	28,910	54,100	20	66
17	30,950	56,600	20	52
18	33,010	59,100	20	27
19	35,080	61,500	19	358
20	37,180	63,900	19	317
Age 60	46,200	72,000	18	111
Age 65	55,040	78,600	16	147

Paid-up additions and dividend accumulations increase the cash values; Indebtedness decreases them.

- **Loans**—The policy loan provision allows the owner to borrow against a permanent insurance policy's cash value. The applicable interest rate and loan provision are specified in the policy as either a fixed or variable rate.

- **Dividends**—The right to receive dividends is among the most important ownership provisions in participating life insurance policies. The company estimates conservatively its anticipated investment returns and mortality when calculating premium rates. As a result, an extra "safety margin" exists which may be returned to the policy owner in the form of annual dividends. It's important to note, however, that dividends are not guaranteed. Also, a life insurance dividend is a return of premium, so no taxable event occurs. Using the dividends to best meet the client's needs is a contractual right of every policy owner, and the dividends can be exercised in a variety of ways, including:

    1. **In Cash**—Take the dividend as a cash payment.
    2. **Reduce Premiums**—Apply the dividend against the premium to reduce the gross premium due each year.
    3. **Buy Paid-Up Additions**—Use the dividends to buy paid-up life insurance. Under this option the company uses the dividend as a single premium to buy a miniature version of the original policy, with all the same guarantees, rights, and privileges as the basic policy. Each of these additional units has its own cash value which is at least as much as the dividend itself. As with any regular single-premium policy, the cash value will increase each year and, if the paid-up addition is participating, the policy is eligible for dividends in its own right. The death benefits purchased as paid-up additions are paid to the beneficiary over and above the benefits from the basic policy.
    4. **Accumulate at Interest**—Leave the dividends on deposit with the company to accumulate interest. A minimum rate is stated in the policy, but the rate is often higher than the minimum rate stated in the policy.
    5. **Buy One-Year Term Insurance**—Use the dividends to buy one-year term insurance equal in amount to the policy's guaranteed cash value at that time. Any portion of the dividend not needed to buy the term insurance is applied under one of the other dividend options. This amount of insurance is paid to the beneficiary in addition to the benefits payable from the basic policy. If the full cash value has been borrowed, this dividend option will assure that the beneficiary will receive no less than the face amount of the basic policy. The selection of dividend options is revocable and can be changed each year.

6. **Vanishing Premium**—Vanishing premium is not a name of a policy, but rather a term used to describe what a policy can be made to do. It describes a situation where the policy owner can stop paying premiums after a period of time, yet have the insurance protection remain in force for a lifetime. Other terms used to describe the vanishing premium idea are "accelerated premium payment," "disappearing premium," or "premium offset." Unlike a paid-up policy, wherein no additional premiums are paid, vanishing premiums continue to be paid, but in time they are paid out of policy values and policy dividends, not directly by the policy owner.
7. **Settlement Options**—Life insurance is purchased to provide a benefit to someone. When that benefit is paid to a beneficiary, it can be disbursed as a lump sum or in a variety of other ways, called settlement options. These options offer payees a choice of how to receive or use the benefits. For example, settlement options can be used for death proceeds, cash surrender values, or other money turned over to an insurance company for payout under one of these options. All but the first of these options is a form of annuity payment.
8. **Interest Payments**—Proceeds are left with the insurance company and periodic interest is paid to the beneficiary.
9. **Installment Payments for a Specified Period**— Proceeds are left with the insurance company, at which point periodic payments of principal and interest are paid to the beneficiary on a monthly, quarterly, semi-annual, or annual basis, for the length of time specified.
10. **Installment Payments of a Specified Amount**— Proceeds are managed as above, except that a specified amount of principal and interest is paid periodically until the proceeds are exhausted.
11. **Life Income**—The life income option is a unique financial device offering a variety of options and found only in the life insurance business. The one thing they all life income options have in common, however, is an unconditional promise to pay a stated level of income for as long as the payee lives.
12. **Certain Life**—One kind of life income option makes an additional promise to pay the income for a "certain" period of time, even if the recipient dies soon. For example, under a 10-year-certain life income option, income would be paid for the insured's lifetime, but for at least 10 years, even if the recipient dies before 10 years.

Policy Riders

The provisions outlined above are integral parts of most life insurance policies. In addition to these, policies riders, or optional features can be added at the discretion of the policy owner for an additional premium. Typically, if added at all, policy riders are included at inception. However, some insurance companies allow the addition of policy riders later, if satisfactory evidence of insurability is provided. Some examples include:

- Accidental Death Benefit—The accidental death benefit in a life insurance contract promises to pay an additional sum of money to the beneficiary if the insured's death was caused by something other than natural causes. The additional sum of money is generally equal to the face amount of the policy and is commonly known as "double indemnity." Likewise, triple indemnity pays an additional amount equal to twice the face amount of the policy if death is accidental.

  The addition of accidental death insurance is a way to take a chance on a big payoff. Actuarially, of course, the cost of the accidental death benefit is low because the chances of dying from an accidental death are low. The key to the value of the accidental death benefit lies in whether or not an accidental death as defined in the policy takes place. **The benefit should be used as a supplement to a base policy which assures payment of sufficient insurance regardless of the occurrence or nonoccurrence of an accident.**

- Waiver of Premium—Typically, this benefit provides that the policy will continue in force without payment of premiums as long as the insured is totally disabled for at least six months. In addition, any premiums paid during those six months of disability will usually be refunded to the policy owner.

  If the waiver of premium rider is part of a permanent life insurance policy, the cash values will continue to accumulate. If it is a participating policy, dividends will continue just as though the premiums were being paid. Any premiums waived under this benefit will not reduce any amounts payable under the policy—cash values or death benefits.

- Guaranteed Insurability Rider—This benefit guarantees the future insurability of a newly insured person by providing the policy owner the right to purchase additional life insurance at specified future ages, regardless of insurability at that time. The right to purchase additional insurance at standard rates despite poor health is a great opportunity for

those who couldn't otherwise buy insurance at all, or couldn't buy it at standard rates.

While the option ages to purchase additional insurance will vary from company to company, typical option ages are 25, 27, 29, 31, 34, 37, and 40. Sometimes other "dates" are offered, such as marriage of the insured, birth or adoption of a child, and other specified ages negotiated before the rider is issued.

The amount of new life insurance which can be purchased under this rider is limited to a specified maximum, and it may bear a relationship to the face value of the basic policy purchased. Regardless of the name given to this rider—future purchase option, guaranteed purchase option, guaranteed insurability benefit, or guaranteed issue rider—its purpose is to guarantee one's ability to qualify for standard insurance at some future time.

This option is popular in situations in which there is a higher likelihood that more insurance will need to be purchased in future years; for example, policies belonging to children, young married couples, people beginning new businesses, and policy owners involved in buy-sell arrangements.

- Cost-of-Living Rider—Many insurance companies offer a cost-of-living feature, either built into the product, or as an optional rider. Generally, a cost-of-living adjustment (COLA) is made every three years based on some index, such as the Consumer Price Index (CPI). If the CPI has increased since the last option date, or issue date, the policy owner may opt to increase insurance coverage on the next option date without evidence of insurability.

Types of Life Insurance Policies

Although life insurance policies contain a seemingly endless number of provisions and benefits, there are, in general, only three factors that account for the major differences among the various kinds of policies:

1. The premium-paying period stated in the policy;
2. The insurance-protection period stated in the policy and;
3. The amount of guaranteed cash promised when protection stops. Specifically:

    - No cash
    - An amount of cash equal to the policy's face amount or
    - An amount of cash greater than the policy's face value

As a rule, if we know what these few factors are, we can apply a descriptive name to the policy.

Quite often, life insurance policies are categorized as term or temporary and permanent. Unfortunately, this categorization leaves no room for including retirement income policies or many of the endowment plans of insurance, such as short-term endowments, or endowments that mature prior to the end of the mortality table (typically age 100).

This section will categorize life insurance policies as term insurance, permanent insurance, and endowment insurance. In addition, an entire section is dedicated to covering several relatively new insurance products as well as variations of older ones. Annuities will be described separately.

In brief, term policies furnish life insurance protection for a limited number of years, paying a benefit only upon death and only if death occurs during the term of the contract.

Permanent policies, on the other hand, provide protection for as long as the insured lives, paying a benefit whether the insured lives or dies, either as a benefit to the policy owner if the insured survives the term of the contract, or to the beneficiary if the insured does not. For example, if 32-year-old Lee buys a $50,000 permanent whole life policy on himself, $50,000 will be paid to Lee in 68 years, when he reaches age 100, or to Lee's beneficiary if he dies before them, as is likely.

Endowment policies pay the face amount of insurance at the earlier of two possible outcomes; the insured's death or when the policy owner reaches a stated age. In some cases, the policy is paid after a stated number of years.

Retirement income policies promise to pay an amount of cash at maturity greater than the policy's face amount. Such policies are known variously as income endowments or retirement income policies.

Term Insurance

Generally speaking, term insurance may be regarded as temporary insurance. A term policy typically covers a specific risk for a limited time, and then terminates without value. Some terminology and policy options specific to term life insurance include:

- **Renewability**—Although term policies may be issued for a period of time as short as one year, they are customarily written for periods of five, 10, 15, or 20 years, or to a specific age. Such policies may insure for the stipulated term of years only, or may be renewable for successive term periods at the option of the insured.

  Experience shows the great majority of policy owners in poor health take advantage of their renewal privileges, even in light of the increased

premiums. As a result, renewable term fills a valid need by protecting the insurability of the policy owner for the period of the policy.

- Convertibility—Most term policies allow the policy owner to convert from term to permanent insurance without providing evidence of insurability. This is a valuable privilege, particularly to a person with a history of medical issues or other risk factors. However, the opportunity to upgrade is paid for by the policy owner. Generally, those in poor health tend to convert more readily than those in good health, and, because the permanent insurance that is issued upon conversion is the same as that issued to persons who have passed a test of insurability, the company faces a greater mortality risk. To offset this risk, the company includes in the term premiums an extra charge to meet the future excess mortality costs on the converted policies. Despite this extra charge, premiums for term insurance are still relatively low.

- Annual Renewable Term—The most simple form of life insurance is the annual renewable term (ART) contract. The ART plan provides insurance for a period of one year only, but allows the insured to renew the policy each year. The net premium, excluding provisions for expenses and contingencies, increases each year at exactly the same rate as the company's mortality experience for the attained age of the insured.

- Term to a Specified Age—Most term contracts provide protection for a relatively short period of time. Some, however, such as the term-to-age-65 contract or term-to-age-99, provide protection during the individual's normal working period. Although a long-duration term insurance policy is strictly a protection contract, a level premium over an extended period of years produces reserves which increase to a point, then decline to zero at the termination of the policy. Such contracts also usually provide a conversion privilege, only valid until the policy expires.

- Decreasing Term—Decreasing term insurance is frequently available as an individual policy or as a rider added to a basic policy. It is used most often as mortgage insurance or for family income needs. The decreasing term mortgage policy or rider can be used to cover the declining balance of a mortgage by providing a large amount of initial coverage with a declining amount each year thereafter. Premiums are level for the duration of the policy. Like other term policies, the result is an increasing rate per $1,000 of insurance, as the amount of insurance declines each year.

- Re-entry Term Insurance—With all insurance pricing, the anticipated mortality experience of an insurer is more accurate in the early years than in the later policy years. The early-years mortality is called "select" mortality. Over the years, people have changes in health, habits,

occupation, and so forth rendering the mortality experience more difficult to predict. This latter experience is referred to as "ultimate" mortality. It is on this basis (select ultimate mortality) that companies developed re-entry term.

Re-entry term is a renewable, convertible, level death benefit term life insurance product that periodically, usually every fifth or tenth year, allows the insured to apply for a premium rate lower than the guaranteed rate. As the effect of the initial underwriting wears off, the insured is allowed to reapply, at company expense, for a lower rate, subject to new evidence of insurability. Thus, the insured may be eligible for a new "select" rate at a substantially reduced premium. If the insured does not submit evidence of insurability, or does not meet the underwriting requirements for the lower rates, the existing policy is continued at the higher "ultimate" rates guaranteed in the contract.

Re-entry term is attractive because of its low initial cost and is often sold in cases where there is a need for large amounts of term insurance and the individual is a "standard risk." By purchasing re-entry term, the insured accepts the risk that premium rates may be very high at a future date.

Permanent Insurance: A History

The permanent life insurance contract is probably the most flexible and ingenious life insurance plan ever conceived, yet it has been subject to a variety of conflicting interpretations. Many educators feel that it is too technical to be understood and therefore must be explained by an analogy that splits it into two components: protection and savings.

Some actuaries attempt to separate the contract in order to make cost comparisons. In other cases, agents divide it in an effort to persuade their clients that they can invest their money better elsewhere. Although the permanent life insurance contract contains no wording to support divisibility, such misinterpretations still persist.

Looking back at the history of the permanent whole life contract, it is easy to see how the perception of it has become obscured. Roughly 200 years ago, a mathematician, James Dodson, conceived of a way for a policy owner to pay the same premium for life insurance each year, despite advancing age, and guarantee a death benefit to a beneficiary regardless of when death occurred. Dodson devised a premium table based on mortality patterns, the law of averages and compound interest. Then, by leveling the premiums, he averaged the cost of insuring the risks of older age, and created a plan whereby people could continue a life insurance contract for as long as they lived. In order to provide a level premium, the plan had reserve funds which could be invested, this reducing the cost to policy holders.

About a century later, Ellizur Wright developed a method to calculate the values of terminated permanent policies, thus giving rise to the concept of nonforfeiture provisions. Wright, who believed the policy holder had a right to any policy reserves, introduced the "savings account" concept which suggested that, with each premium payment, the addition to reserves was similar to a deposit in a savings account the policy holder could demand at any time.

As a result, the permanent contract was conceived as having two parts: a decreasing amount of life insurance and an increasing investment element. When combined, the two components are always equal to the face amount of the policy. This represents one concept that prevails today. However, many maintain that the level premiums of the whole life contract are not computed by adding together "investment" and "protection" components; rather they are calculated as the level price for all the benefits in the contract, including full death benefits at death or cash values at surrender. The premium is an indivisible sum and the contract is an indivisible product.

When James Dodson created the original level premium plan he did not put together a decreasing insurance policy and a savings account. However, with the development later of Wright's nonforfeiture values, an analogy came into use to help explain the guarantees under the contract. The problem emerges when analogy is substituted for fact.

A reading of the whole life contract reveals its true nature:

"The whole life insurance contract is a contract of protection—an arrangement by which the insured, upon regular payment of a level premium—is guaranteed that, upon his death, the named beneficiary will receive a stated amount."

While the central purpose of the contract is insurance protection, it also provides auxiliary rights to the policy holder during his lifetime if the original arrangement is not continued. These rights stem from the level-premium plan, the effect of which is to collect from the policy owner more than the cost of the pure risk in the early years to permit accumulation of a reserve against the risk of the later years, when the level premium alone would be insufficient.

In other words, level-premium life insurance makes it possible for a policy owner to meet, with a level outlay, a situation in which the risk of his death is constantly increasing. The event insured against is not something that might happen; it is something that definitely will happen. The purpose of cash values in the contract is not to set up a savings account, but rather to build a reserve against the increasing risk as the insured ages. This is the primary function of the whole life policy. The nonforfeiture rights are secondary rights, inherent in the contract.

In the legal and the contractual sense, the whole life plan is indivisible and is not a form of savings. Regulations in a number of states prohibit the use of the word "deposit" or similar language that might suggest a premium is a form of savings. A life insurance contract may not be characterized as a savings or investment account, and a policy owner must never be misled into thinking that he has made an investment in the conventional sense.

With that in mind, multiple options are available within the scope of permanent insurance, including:

- Whole Life—The policy plan first developed by William Dodson in the 1700s was the level-premium whole life insurance policy. There are three elements which, combined in a particular way, gave this type of policy its name:

    1. Premiums are payable to, and remain level until, the insured reaches age 99.
    2. The insurance protection extends for the whole of one's life, up to age 100.
    3. The policy will "mature" for the face amount of the contract when the insurance period ends (at age 100) and the policy owner will be paid that amount in cash at that time.

  Theoretically, at least, the same premium is paid every year through age 99. As a practical matter, however, even among persons who live to this advanced age, few would likely continue premium payments beyond age 65 or 70. The wonderful feature of the whole life plan is that, by age 65 or 70, most policies will have accrued very substantial benefits. These values vary, of course, depending on the insured's age when the policy was issued. Policies purchased at young ages, for example, will have more cash, therefore, more paid-up insurance at age 65. The point that is not well understood is that the insured is in the metaphorical "driver's seat." He may choose at any time to quit paying and take paid-up insurance, extended term, cash or an income. Or he can continue to make premium payments, keeping the maximum amount of insurance in force and increasing cash accumulations.

  As you will see later, the whole life policy is the foundation for virtually all other plans of permanent life insurance. A variety of novel elements have been added to many plans, but, by and large, they are merely variations of whole life because they do not represent structural changes in the three major policy elements---premiums, protection, and cash.

- Limited-Pay Plans—The 10-pay, 20-pay, 30-pay, and life paid-up-at-65 plans are standard variations of whole life. They differ only in that they

are paid-up in full before age 100. The shorter payment period naturally indicates a higher premium, and larger cash values must be accumulated.

Key distinction to note: A paid-up policy indicates that a given amount of insurance protection requires no further premium payments. A matured policy, on the other hand, indicates the insurance element has expired and an equal amount of cash has been paid to the policy owner. After maturity, no insurance is in force. With a paid-up policy, however, insurance continues until the insured dies. By age 100, all policies have matured.

- Single-Premium Plan—The single-premium policy is a one-pay life, and, as with the limited-pay plans mentioned above, it is simply a variation of whole life. Single-premium denotes the ultimate compression of the premium-paying period, while the other two major factors of whole life policies are unchanged. That is, insurance protection extends to age 100 and the amount of guaranteed cash promised when the protection period stops, typically age 100, is an amount equal to the policy's face amount.

- Endowments—The distinguishing feature of the endowment policy is that the face amount is paid to the insured policy owner at the end of a specified number of years, or at a specified age of the insured. If death occurs prior to the maturity date, the face amount will be paid to the named beneficiary. The premium-paying periods for endowments cover a range much like those for whole life plans. For example, the premiums may be payable for the entire duration of the protection period, or they may be compressed, even down to a one-pay endowment if so desired.

  The variety of endowments available is virtually unlimited. Policy holders can choose from 10-year or 20-year endowments, endowments at age 65, endowments at age 100, and so forth. The significant factor to remember with endowments is that insurance protection ends when the policy matures or endows for its face amount.

  "A ha!" moment: In reading the preceding description of endowments, you may have discovered what most people never know: whole life policies are essentially long-duration endowments. Endowments at age 100, to be precise.

  If the insured lives to age 100, the face amount of the policy will be paid to him at that time. If death occurs before age 100, as is likely, the face amount of the policy will be payable to the named beneficiary.

  The fact that whole life policies are really endowments at age 100, provides many people with a much clearer understanding of the various

types of life insurance policies, as well as new categorization of policy plans. Once this concept is understood, all life insurance policies can be categorized either as term or endowment policies. For example, a 20-payment life policy could be accurately described as a 20-pay-endowment-at-age-100 policy. Or, for a 35-year-old policy holder, a life-paid-at-age-65 plan could accurately be viewed as a 30-pay-endowment-at- age-100. Although this categorization could cause confusion for clients, it is often a helpful way for financial advisers to understand policy plans.

Variations on a Theme: More Policies

Not everything is as neat and tidy as the preceding descriptions might indicate. For example, the insurance industry generally views any endowment that matures in the age 90s as a whole life policy. The same is generally true for any policy that calls for premium payments into the age 80s or 90s. Other industry practices address flexibility in premium payments, changes in face amounts, and other variations in policy benefits. Some examples of such variations include:

- Graded Premium Whole Life—This is a traditional whole life policy, with the exception that premiums and cash values start lower and build up gradually. Typically, the initial premium is comparable to a premium for a term insurance policy. Then, the premium increases according to a schedule, reaching an ultimate premium in some given year, generally the 10th, 11th or 21st year, depending on the company. If the policy is a participating one, dividend illustrations will often reflect the premium-reduction option, thereby keeping premiums somewhat level after the first few years.

  The ultimate premium will generally be higher than a level-premium policy issued at the same original age. Cash values are generally lower than a traditional whole life policy issued at the same age because premiums are lower.

- Survivorship Life—Also referred to as second-to-die, or last-to-die, these policies insure two or more lives and pay the death proceeds upon the death of the second or last insured to die. Survivorship policies can be either whole life, term, or universal life policies.

  Pricing of survivorship life policies is based on the probability of having to pay benefits at the death of someone other than the first to die. It is a form of joint life insurance and has premiums that are less than the cost of separate policies on each of the insured's. While premiums normally continue after the first death, some products provide that premiums cease at the first death, or offer this feature as a rider.

- Indeterminate Premium Life-This type of policy is marketed by stock companies in response to participating whole life insurance. The product

is nonparticipating with a level death benefit, but with an initial premium lower than traditional nonparticipating whole life. The initial premium is guaranteed for a specified period, such as 3 or 5 years, at which time the annual premium may be adjusted, but not to exceed a guaranteed maximum premium stated in the policy.

Indeterminate life policies are similar to participating insurance with dividends used to reduce premiums. However, with a participating policy, dividends are based on experience for the past period of protection; whereas with indeterminate premium life, premiums are based on anticipated experience.

- Current Assumption Whole Life—In recent years, a number of companies developed whole life products using current interest and mortality assumptions as a means to improve their competitive position. In essence, current assumption whole life is a version of whole life which uses both current mortality and interest earnings based on current yields rather than overall portfolio yields. In all other respects, it is identical to conventional whole life.

  The current assumptions are reflected in different ways, depending on whether the company is a stock or a mutual company. For instance, mutual companies generally reflect their current assumptions through the dividend formula, whereas stock companies tend to reflect theirs through the cash values and/or premiums.

- Indexed Life—Indexed life policies provide for increases in the death benefit based on an index, such as the S & P 500 stock index. The purpose is to help the client maintain the policy's purchasing power. Depending on the policy, the increase may be automatic or elective at the option of the policy owner.

  Those policies providing automatic increases have a constant premium, with a charge for this has included in the premium. Conversely, policies with elective increases require an additional premium each time the policy owner exercises an option to increase the death benefit. In both cases, however, the additional insurance is available without evidence of insurability. Generally, if an option is not exercised, future options are cancelled, but may be reinstated by providing satisfactory evidence of insurability.

  Many companies offer a cost-of-living policy rider that is similar to this product.

- Adjustable Life Insurance—An adjustable life insurance product contains all the usual features of traditional cash value insurance with the added flexibility of allowing the policy owner to adjust the plan of insurance, the premiums and/or the face amount. Rather than issue a new policy every time an adjustments is made, changes are incorporated within the original policy. Increases in face amount, except guaranteed cost-of-living increases, generally require evidence of insurability.

  The plan of insurance is deemphasized with adjustable life. Instead, the major thrust is to coordinate current life insurance needs and premium-paying ability. As either of these changes, the plan of insurance can be adjusted. At any given time, the plan may be term or permanent insurance, ranging from five-year term to five-pay whole life. Adjustable life can be changed, within limits, in a number of ways. For example, the policy owner may:

  - Increase or decrease the premium
  - Increase or decrease the face amount
  - Lengthen or shorten the protection period
  - Lengthen or shorten the premium-payment period

- Universal Life—This flexible premium adjustable death benefit policy credits current investment yield to the accumulated cash value. Universal life products are also referred to as "unbundled" life insurance because its three components are separately identified: earnings, protection costs, and expenses.

  Premiums are paid to the insurer periodically and, once a month, the insurer takes out sufficient money to cover expenses and mortality charges for the next month. The balance of the premium is added to the cash value, and the entire cash value is credited with the investment yield.

  This product has a number of flexible features. For example, at any given time, the policy holder may adjust the amount of insurance coverage, the amount of premium, and the frequency of the scheduled premium payments. In addition, as with traditional whole life insurance, the cash value is available for use by the owner during the life of the contract.

  Initially the policy owner selects the amount and frequency of premium payments, then, after meeting a minimum first-year premium, payments are flexible. These scheduled premium payments may be increased or decreased, subject to limits imposed by tax law and the life insurance contract, and may stop and start at the policy owner's discretion. Lump sums can also be paid-in, thus, granting the policy owner a degree of control over the amount of cash value in the policy.

- **Variable Life**—Variable life is, above all else, a form of life insurance designed to provide protection against the certainty of death, just like all other forms of life insurance. In addition, the death benefit and cash value of variable life policies may change in ways that reflect our changing economy.

  Variable life is similar to traditional whole life insurance in that it has level premiums, loan, and surrender values. The basic difference lies in the underlying assets supporting the product. Unlike traditional whole life, it is supported with funds from separate accounts, usually equity accounts, invested in designated investments. The policy owner generally has a choice of two or more separate accounts in which to allocate the portion of the premium dedicated to cash values, and the death benefit and cash value will increase or decrease based on the investment performance of the separate account. Generally a minimum death benefit is guaranteed, however, the policy gives the insured an opportunity to benefit from certain investment choices. Likewise, the policy owner assumes a certain portion of the risk inherent in the separate account of their choosing. The bottom line, though, is this: variable life is still life insurance, purchased primarily to provide a death benefit.

  Variable life is governed by certain Securities and Exchange Commission regulations and can be sold only by FINRA registered representatives. Policy owners receive annual policy status report and semi-annual financial statements and lists of portfolio securities.

- **Flexible Premium Variable Life**—This product combines features of universal life and variable life. On the variable side, the policy owner can make direct investments within the policy into separate accounts. However, since investment performance will influence cash values and death benefit, the policy owner accepts all investment risk. In terms of universal life features, this type of policy includes the ability to increase or decrease premiums, add single sums to the cash value, and change insurance amounts.

  While the policy generally contains a guaranteed minimum death benefit, it requires a minimum premium in the first year, but permits fluctuations in subsequent years. As with universal life, the policy owner can increase or decrease the death benefit, but must remember that investment performance can also significantly affect the amount of the death benefit. The cash values will increase or decrease depending on the policy owner's choice and investment results, and the amount of premium that is allocated to the cash value portion.

Following are abbreviated descriptions of some types of life insurance policies.

Product	Features/Benefits
Ordinary Life	- Level premium to age 100. - Offers greatest protection for a given level premium amount among traditional level premium permanent policies. - Guaranteed death benefit and cash values are virtually risk free. - Low minimum coverage levels mean increased accessibility. - Additional riders available for improved flexibility of coverage. - Can stop premiums and use non-forfeiture values to keep protection in force. - Loans are available. - Tax-deferred cash value growth and tax-free death benefits. - Dividends in participating plans.
Limited Pay Life	- Lifetime protection. - Level premiums for 10 or 20 years, or to age 60 or 65, will allow premiums to be paid during peak earning years. - Higher premium outlay typically provides faster cash value accumulation. - Cash value increases as long as policy is in remains in force. - Same nonforfeiture values as Ordinary Life.

Product	Features/Benefits
Graded Premium Life	- Lifetime protection. - Premiums increase in graded steps for the first 10, 15, or 20 years. - Same cash value and nonforfeiture guarantees as other permanent policies.
Universal Life	- Flexible premiums, adjustable coverage. - Increasing coverage typically with no increase in premium. - Cash value can accumulate at attractive current interest rates. Minimum guaranteed cash values provided. - Generally higher minimum policy amounts than Ordinary Life. - Choice of death benefit options allows emphasis on cash build-up or protection. - Annual Report shows policy activity. - Policy loans and partial surrenders are available. - Additional benefit riders typically are available.
Variable	- Level premium, higher premium per $1,000 to achieve early cash value. - Typically guaranteed minimum death benefit. - Policy owner can control investment element in policy by directing investment to equities, money market, or bond funds, each of which are deemed sub-accounts or separate accounts. - May switch money between investments once or twice per year, or multiple times during the year, depending on the contract provisions.

Variable (Cont'd.)

- Cash value not guaranteed, but potential is great for a higher return if the sub-accounts perform well. Policy holder risk generally increases if performance inside the sub-accounts is poor.
- Additional benefit riders available to provide flexible coverage.

Variable Universal Life

- Combines key features of Universal and Variable Life.
- Insured selects protection amount and premium schedule.
- Flexible premiums can be directed to one of several sub-accounts allowing policy holder to have investments in equities funds, money market funds, and bond funds.
- Policy owner can adjust combination of cash value and term insurance by increasing or decreasing premium payment amount.
- Additional benefit riders available.
- Protection stays in force as long or cash amount is large enough to cover term insurance costs.
- Potential reward is significant.
- Potential risk is also substantial; responsibility for premium payments and investment decision is with the policy owner.

Level Term Insurance

- Level premiums with temporary death benefit.
- Maximum temporary protection for lowest premium outlay.
- Various term periods available including one-, five-, 10, and 20-year terms with some insurance companies offering up to a 30 year term.
- Ideal coverage is renewable and convertible.

Level Term Insurance (Cont'd.)

- Available as separate policy or as rider to permanent (base policy) protection.
- Premium increases at each renewal, based on the insured have attained age.
- Some insurance companies also have the return of premium (ROP) term which pays the owners' premiums back to them at maturity.

Decreasing Term Insurance

- Decreasing protection.
- Available for various term periods, including 10, 15, 20 or 30 years.
- Generally guaranteed convertible but usually not renewable.

DISABILITY INCOME INSURANCE

Disability income insurance protects the insured against loss of earned income.

Degrees of Disability

There are varying degrees of disability. For example, A person may be completely incapable of working, or impaired in a way that prevents him from working a full schedule or precludes the type of work he was able to perform before the disability. Generally, the ranges of disability are defined as follows:

- Own Occupation, Any Occupation—This is usually recognized in the contract by providing one definition of disability to cover the initial stages of impairment, and another definition to take into account that the patient might be capable of earning a good income in a different line of work.

  A dentist, for example, might have a policy calling for payments to age 65 in the event of disability due to sickness, and a longer period (perhaps lifetime) for disability due to accident. The contract would most likely provide one definition of disability to apply during the first portion of the benefit period, perhaps five years, and a different definition to qualify for benefits beyond that time.

  For the first five years, disability might be defined as "inability to perform all the important duties of the regular occupation." A disability impairing the use of both hands would obviously prevent a dentist from performing all the important duties of a dental practice.

  The policy might define disability after five years as "inability to engage in any occupation for which the insured is reasonably qualified by virtue of age, education, training and experience." A dentist unable to engage in the general practice of dentistry most likely could find productive work in some related field, perhaps as a teacher.

- Residual Disability—Certain forms of coverage provide for the payment of a reduced benefit for residual disability. In such cases, residual disability typically must cause a reduction of 20- to 25-percent of pre-disability earnings to trigger benefit payments. Benefits generally stop when the benefits payable fall below a stated minimum, say $200. All benefits cease when the maximum benefit period ends, or when earnings return to 75- to 80-percent of pre-disability earnings.

- **Partial Disability**—Policies often contain a provision for partial disability during recuperation. Each company determines its own approach to this, but on average, half of the income benefits would be paid while the insured is able to perform only one or more, but not all, of the duties of the occupation.

  For example, suppose the insured is an attorney who frequently represents clients in court, but who spends more time in preparation or analysis of legal documents. A broken jaw would prevent performance of some duties, namely arguing a case in court, but would not interfere with other work. In this case, the benefit would be partial—usually one-half the amount provided for total disability.

  In most cases, partial disability is limited to six months and, on the whole, contracts specify that partial disability payments will be applicable only following a period of total disability as defined by the contract. This is particularly true in the case of partial disability due to sickness.

Types of Disability Insurance Contracts

Disability insurance contracts fall into five classifications with respect to cancellation and renewal:

1. **Cancellable**—A cancellable contract may be terminated by the insurance company simply by giving due notice, without stating a reason.

2. **Optionally Renewable**—The insurance company has the right to terminate an optionally renewable agreement at any anniversary or, in some cases, at any premium due date. The company cannot, however, terminate the coverage between such dates.

3. **Conditionally Renewable**—In this type of contract, the company reserves the right to refuse renewal under conditions defined in the policy. Unlike optionally renewable policies, the company must have a specific reason for refusing to renew a conditionally renewable policy. Furthermore, that reason must be explicitly allowed by the contract. For example, discontinuation of such policies in a particular state, or a change in the status of the insured.

4. **Guaranteed Renewable**—Under a guaranteed renewable contract, the insurance company must continue to renew the contract for a substantial period of time, as set forth in the policy, as long as the insured pays the premiums. In addition, the company is prevented from making any change in policy provisions. The only exception is that it may change the

premium rate for entire classes of insured. In other words, at the time of renewal the company cannot change the premium for an individual policy holder unless it does the same for all policy holders in the same class. The guaranteed renewable disability income insurance policy carries all the same rights for the insured as a noncancellable policy, except the premium rate is not guaranteed.

5. Noncancellable—Also commonly referred to as a noncancellable guaranteed renewable policy, this type of disability income insurance most closely resembles a life insurance contract. The premiums must be guaranteed and stated in the contract and the insurance company only must continue to accept premiums and keep the insurance in force for the stipulated period. Additionally, the company cannot change any policy provision during that time. Generally, the term "noncancellable" cannot be used unless the policy holder has the right to renew to age 50, or for a minimum of five years, whichever is longer.

GROUP INSURANCE

By definition, group insurance refers to a policy that provides insurance coverage for several people under one contract, called a master contract. Often the group is comprised of employees of the same company, members of the same association and their dependents. Based on frequency of purchase, the most popular kind of group coverage is medical care insurance. The second most frequently purchased group coverage is term life insurance, which is often added to the medical-care group insurance plan. Increasingly, disability income protection is added to the package.

Businesses can include a wide variety of coverages in its group insurance plan, typically within three main categories:

— Life Insurance —

Employee Coverage
Accidental Death and Dismemberment
Post-Retirement Death Benefits
Permanent Insurance
Dependent Coverage
Survivor Income

— Health Insurance —

Hospital
Major Medical
Comprehensive
First-Dollar Coverage
Deductibles
Coinsurance
Accident Deductible Waiver
Maternity Benefits
Diagnostic X-Ray and Laboratory
Dental Care
Vision Care
Prescription Drugs
Well-Baby Care
Skilled Nursing Care
Home Health Care
Survivor Health Care
Post-Retirement Health Care
Second Surgical Opinion

— Disability Income —

Short Term
Long Term

Some of these coverage's will be discussed briefly on the following pages.

Group Term Life Insurance

Group insurance plans must meet various eligibility and level of benefits requirements in order for premiums to be tax-deductible by an employer. For this reason, it can be fairly said that taxation goes a long way in molding important decisions about group insurance plans. For instance, the amount of group life insurance provided for employees must be decided carefully so as to remain within tax-deductible parameters.

Group life insurance is defined as an employer-provided benefit, payable while the insurance is in force, to the beneficiary named by the employee in the event of death from any cause. Such life insurance is nearly always term insurance. During the 31-day period immediately following termination of employment, an insured employee may convert, without evidence of insurability, all or part of his life insurance coverage to an individual permanent insurance policy.

In most states, the employer is allowed to include term life insurance on dependents of employees. A typical schedule for such additions generally falls in the range of $5,000 of insurance for the employee's spouse and $1,000 of insurance on dependent children of the insured.

Group Medical-Care Insurance

Although this section pertains to group medical-care plans, it also adequately describes most examples of individual medical-care policies. Many people who are not insured under group plans purchase coverage under individual medical plans. Premiums for individual policies are substantially higher than the per-person cost of group plans.

Following are descriptions of some of the more important group insurance medical-care plans and means by which benefits are provided:

- **Comprehensive Major Medical Insurance**—One of the most popular types of plans on the market today, this coverage brings together several of the most common individual forms of medical-care insurance. Group Comprehensive Major Medical Insurance generally embraces each of the individual coverages described below. Of course, each of these can be

purchased as individual plans of insurance, but most groups choose to combine them into one comprehensive package. One restriction they all have in common is that they do not cover the expenses of occupational accident or sickness. Those claims are covered, instead, by Workers' Compensation insurance.

- Hospital Expense Insurance—Group hospital expense insurance provides benefits to help defray hospital charges incurred by an employee or dependent during confinement in a hospital. In addition to providing reimbursement for room-and-board expenses up to a stipulated amount for a stipulated number of days, the typical plan reimburses for such hospital charges as anesthesia, operating room costs, X-rays, laboratory tests, dressing, supplies, medicines, and drugs.

- Surgical Expense Insurance—As its name suggests, surgical expense insurance provides benefits for surgical operations. The amount of the benefit is determined either by the actual expense incurred or the amount shown in the policy's maximum payment schedule.

- Medical Expense Insurance—Group medical expense insurance pays some or all of the expenses incurred by the policy holder. Plans vary, but quite often coverage is provided for treatment done at the physician's office, at the hospital, or in the home. Some plans reimburse, other plans provide a specified dollar benefit per treatment.

- Diagnostic X-Ray and Laboratory Expense Insurance—The coverages described above do not include outpatient diagnostic X-ray expenses or the cost of outpatient laboratory tests and examinations. Diagnostic X-ray and laboratory expense insurance bridges this gap.

- Supplemental Accident Expense Insurance— Group supplemental accident expense insurance simply increases the amount of the benefit that will be paid for expenses incurred as the result of an accident.

- Supplemental Major Medical Expense Insurance—All the coverages outlined in this section contain maximum amounts that limit the amount of the insurance company's liability. Major medical expense insurance provides benefits for medical care expenses which are substantially beyond the maximum provisions of the basic coverages.

  The maximum benefit payable under a major-medical plan will normally be quite high, stated as a specific dollar amount, say $1,000,000, or even unlimited. The typical major medical plan will pay 80 percent of all covered medical care expenses, leaving the insured responsible for the other 20 percent. In addition, most policies contain a deductible clause which

specifies that the insurance company's liability does not begin until *after* the insured has paid a stated sum of incurred expenses. For insured persons with a basic plan of coverage, the basic plan will pick up some or all the deductible amount. If there is no basic coverage plan, the insured must pay the deductible. Many major medical plans pick up 100 percent of the expenses after a certain amount of out-of-pocket expenses has been incurred by the insured.

Group Disability Insurance

Group disability insurance is classified either as short term (STD) or long term (LTD). As with group life insurance, the benefits are reliable so long as the policy is in force. Again, group plans should be viewed as supplemental to personally owned disability coverage.

- **Group Short-Term Disability Insurance**—as the name implies, a short-term disability plan provides income benefits to a disabled worker for a limited period of time. Short term, in this case, generally means a period of time ranging from a quarter of a year to a full year. A typical plan might pay weekly benefits starting with the first day of an accident or with the eighth day for a sickness. Benefits are usually limited by a schedule published by the insurance company. Group short-term disability plans are generally renewable at the option of the insurance company, so neither the rates nor the benefits are guaranteed.

- **Group Long-Term Disability Insurance**—A typical group long-term disability insurance plan provides benefits to age 65 with waiting periods ranging from 90- to 360-days, depending on the wishes of the employer. Benefits are usually limited to a stipulated percent of salary, and to a stipulated maximum dollar amount. Long-term group disability income contracts are renewable each year at the option of the insurance company and can be terminated or changed upon short notice.

ANNUITIES

An annuity is a contract that provides periodic income at regular intervals for a specified period of time and is issued by an insurance company. The specified period of time might be a number of years or for life. Although annuities exist outside the life insurance industry, this section will limit itself to a discussion of annuities issued by life insurance companies. A number of variations in annuity designs exists. For example, annuities may be:

- Immediate or deferred
- Fixed or variable benefit
- Single or a series of premiums
- Fixed or flexible premiums.
- Fixed or variable.

An annuity's starting date will be either immediate or deferred depending on whether the annuitant wants benefit payments to begin immediately or sometime in the future.

The premium-paying period for an annuity may be compressed into a single premium, or extended over many years, prior to the commencement of benefit payments. Premiums may be fixed or flexible at the discretion of the annuity owner, depending on whether he wants to lock into depositing a fixed amount every year or have the ability to deposit varying amounts.

Annuity benefit payments may be fixed or variable, as well, depending on whether the holder wants a stipulated, guaranteed monthly benefit, or is willing to take a risk and thereby be exposed to higher or lower amounts of monthly benefit without all the guarantees.

Payouts

Annuities issued by life insurance companies promise to pay benefits for at least as long as the annuitant lives. Flexibility exists in several forms within this lifetime-payment promise. For example, the annuity payments may be for life, but with a minimum guarantee as to how much will be paid out by the insurance company in the event of the annuitant' s early death.

This minimum guarantee may come in the form of a promise to pay benefits for a certain period of time, or to pay a certain minimum amount of benefits. The duration and amount of benefits can also be based on two lives, rather than one. These joint-and-survivor annuities have a few flexible variations. For example, a joint-and-survivor annuity may pay one amount while both annuitants live, and then a lesser amount, such as two-thirds or three-quarters of the original amount, to the survivor. As with variations of life insurance contracts, all variations of annuities are actuarial equivalents and the settlement options are the same as those for life insurance proceeds.

GLOSSARY

SPEAKING THE LANGUAGE: INSURANCE TERMINOLOGY

As with most industries and businesses, insurance has its own terminology and vernacular. It's important to speak the same "language" as the agents and home office personnel. Following is a comprehensive summary of common terms used in life insurance and the brokerage business. It will take time to learn these terms, but you will probably be surprised by how quickly many of them become familiar to you.

Absolute Assignment—An irrevocable transfer of ownership of a life insurance policy from one party to another.

Accident—An unforeseen, unintended event, something unexpected. An event which would not be considered as a foreseeable occurrence or consequence of an undertaking.

Accident Insurance—A type of life or health insurance providing a benefit only as a result of death or accidental bodily injury by unforeseen, unexpected or an unintended happening.

Accidental Death and Dismemberment Benefit—A provision purchased in a life insurance policy to provide an additional amount, usually equal to the policy face value, if the insured is killed in an accident. Also known as "double indemnity." The dismemberment benefit, if included, pays a set percentage for the loss of eyesight, and for loss of hands or feet at or above the wrist or ankle.

Accidental Injury—Accidental bodily injury sustained while the policy is in force. Can be defined more narrowly as bodily injury sustained through accidental means. A very limited definition describes bodily injury due solely to external, violent and accidental means.

Accumulated Value—The total amount of money invested, plus the interest earned by that money.

Actual Age—The age of the applicant on the day the application is taken.

Actuarial Department—The home office department responsible for seeing that the company's operations are conducted on a mathematically-sound basis.

Actuary—A highly specialized mathematician professionally trained in the risk aspects of insurance and related fields, such as the calculation of premiums, reserves and other values.

Additional Insurance—Insurance which is added to an already existing policy.

Adjustable Life Insurance—A variety of insurance allowing the policy holder to change the type of insurance, raise or lower the face amount of the policy, increase or decrease the premium and lengthen or shorten the protection period.

Adjuster—A trained individual who acts in settling claims arising out of policy contracts.

Administrator—The person appointed by the court to manage and settle the estate of a deceased person usually because the deceased person left no will. See Executor.

Adverse Selection—Increase in insurance company risk resulting from the tendency of persons with poorer than average health to apply for or continue insurance coverage.

Age at Issue—The age of the insured when the policy is first issued.

Age Change—The date at which an individual's age increases for insurance underwriting purposes. Companies use one of two methods in determining age change: age at last birthday or that date, halfway between birthdays, as the change date with age being the nearer of the two birthdays.

Agency—A department or office within the insurance company responsible for production of new business. In Home Service Companies this also refers to the geographic territory for which the sales representative is responsible. Some brokerage sales operations refer to their marketing offices as agencies.

Agency Underwriting Manual—An abridged edition of a home office under writing manual that presents an abbreviated list of impairments and possible underwriting actions.

Agent—A sales and service representative of an insurance company licensed by the state to solicit the sale of insurance. Life insurance agents may also be called life underwriters or field underwriters.

Agent of Record—The agent or broker who is recognized by the insurance company as the person to whom commissions are to be paid.

Agent's Statement—The portion of the insurance application in which the agent reports additional information about the proposed insured that is not already reported by the applicant or proposed insured.

Amended Policy—A policy on which a change has been made in rates, values, benefits or any policy provision, either before or after delivery, with the acceptance by the insured.

Amendment—The formal document changing the provisions of an insurance policy.

Amount at Risk—The difference between the face amount of a policy and the reserve or policy cash value at a given time. In other words, the amount over and above what the policy owner has contributed in the way of policy cash value toward the payment of his claims.

Anniversary—The yearly anniversary of the policy's issue date.

Annuitant—The person during whose life an annuity is payable, usually the person to receive the annuity income.

Annuity—A contract that provides a periodic income at regular intervals for a specific period of time, such as for a number of years or for life.

Annuity Consideration—The payment, or one of the regular periodic payments, made to an insurance company to purchase an annuity.

Applicant—The person who applies for insurance by signing a written insurance application. The applicant need not be the insured but must have a clear insurable interest in the person to be insured.

Application—A statement of information made by a person applying for insurance. It helps the life insurance company assess the acceptability of risk and issue the policy. A copy of the application is usually made a part of the policy when it is issued.

Arrears—The status of a policy on which the premium is past due, either within or beyond the grace period.

Assignee—The person or business institution who is eligible to receive the benefits of the insurance contract when assigned by the policy holder.

Assignment—The signed transfer by the policy owner of some or all of the rights under the policy to another. After assignment the policy can no longer be changed without approval of assignee.

Assignor—The policy owner who transfers his rights under an insurance policy to another by means of an assignment.

Assuming Company—In a reinsurance transaction, the assuming company is the reinsuring company. By contrast the insurance company that seeks to reinsure some of its original risk is known as the ceding company.

Assurance—Synonymous with the word insurance, this term is more commonly used in Great Britain and Canada.

Attained Age—The age the insured has reached on a certain date, based on nearer birthday. Sometimes referred to as insurance age.

Attained-Age Conversion—Converting a life insurance policy from one form of insurance to another, from term life insurance to whole life insurance for example, at a premium rate that is based on the age the insured person has reached at the time the conversion takes place. (See original age conversion.)

Attending Physicians Statement (APS)—A written statement from a physician who has treated, or is currently treating, the proposed insured. The statement provides the insurance company with information relevant to underwriting a risk or settling a claim.

Automatic Premium Loan (APL)—An elective policy feature wherein any premium not paid by the end of the grace period is paid by the insurance company by making a loan equal to the premium from policy cash values.

Aviation Clause—A clause limiting the liability of the insurer if death is related with aviation.

Back Date—Establishing the policy issue date prior to the date of application, to give the insured benefit of a lower premium rate for a younger than current age.

Balance Sheet—A financial statement listing the assets and liabilities of a business or individual as of a given date.

Beneficiary—Any person, class of people, institution or trust specifically named in a life or annuity contract to receive the policy benefits at the death of the insured.

Beneficiary Change—The named beneficiary may be changed only if the policy gives such right to the policy owner and law permits the change. Most policies allow such change with the formal request and signature by the owner.

Beneficiary, Contingent—The person(s) designated in the policy to receive the benefit if the primary beneficiary dies while the insured is living.

Beneficiary, Primary—The person(s) designated in the policy to receive the benefit at the death of the insured.

Benefit—The amount payable by the insurance company to a claimant, assignee, or beneficiary under the coverage of the contract.

Benefit Period—The period of time that disability income benefits are payable for a particular claim.

Binding Receipt—A receipt provided to indicate temporary protection of the applicant from the date of the receipt, but enabling the company to terminate the coverage if the applicant does not meet underwriting standards.

Broker—A sales and service representative who handles insurance for clients, generally selling insurance of various kinds and for several companies.

Business Insurance—Insurance which serves the insurance needs of a business rather than the needs of an individual.

Business-Continuation Insurance—Life insurance or disability income insurance which provides funds so the remaining partners in a business, or the remaining stockholders in a closely held corporation, can buy the business interest of a deceased or disabled partner or stockholder.

Cancellable Contract—Policies that can be cancelled by the insurer for any reason, usually only at renewal time.

Cancellation—The termination or dissolution of a contract by either the insured or the company.

Cash Surrender Value—The amount available in cash upon voluntary termination of a policy by its owner before it becomes payable by death or maturity.

Cash Value—The cash fund within a permanent life insurance policy that is part of the death benefit and owned by the policy owner for purposes of cash surrender or policy loans.

Casualty Insurance—The term used to refer to lines of insurance including auto, liability, aviation, bonding, theft, and worker's compensation.

Certificate—A statement issued to individuals insured under a group policy, setting forth the essential provisions relating to their coverage.

Children's Rider—Unit(s) of term insurance attached to a parent's life policy to provide a death benefit for all eligible children. Age limitations for coverage usually extend from 14 days to 22 or 25 years.

Claim—Official notification to an insurance company that payment of an amount is due under the terms of a policy contract.

Claimant—The person or party making claim for the proceeds of a policy.

Claim Department—The part of an insurance company that receives and makes settlement of claims and losses.

Claim Form—A printed form furnished by an insurance company to assist the claimant in establishing and substantiating proof of loss; the form may require statements from the claimant, an attending physician(s), an employer, and possibly a group policy holder.

Class Beneficiary Designation—A beneficiary designation that names people as a group, for example "children of the insured," rather than naming each person individually.

Clean-Up Fund—A life insurance death benefit used to pay the insured's outstanding debts and final expenses.

Client—A policy holder of an agent who feels a particular mutual bond of interest and trust with the agent.

Coinsurance—A policy provision for sharing the loss between insurer and insured. For example, a company may agree to pay 80 percent of the insured's medical expenses, while the insured pays the other 20 percent.

Commissioner of Insurance—The state official charged with the enforcement of the laws or regulations pertaining to insurance in the receptive states.

Common Disaster Clause—A clause sometimes added to a policy which defines the method of payment of the policy's proceeds when the insured and the named beneficiary die simultaneously in a common disaster. It states the insured will be deemed to have survived the beneficiary and policy proceeds will be paid accordingly.

Conditional Receipt—A receipt given in return for the application's first premium payment, acknowledging that the insurance is in force from date of the receipt (or medical examination, if later) assuming that the applicant is insurable at standard rates.

Conditionally Renewable Policy—A disability insurance policy that grants the insurance company the right to refuse to renew the policy for reasons specified in the policy.

Contestable Period—A period, normally two years, after a policy is issued during which the company has the right to cancel the policy because of the insured's material misrepresentation, fraud, etc.

Contingent Beneficiary—The person designated to receive life insurance policy proceeds if the primary beneficiary should die before the person whose life is insured. Also called the secondary beneficiary.

Contract—A binding agreement between two or more parties, legally enforceable to do certain things. An insurance policy is a contract.

Contributory—A plan of insurance in which part of the premium is paid by the employee.

Conversion Privilege—(a) The right of a terminating employee who is covered by a group insurance policy to convert his group coverage to coverage under an individual insurance policy. (b) Also, the right to change insurance coverage from one type of policy to another. For example, the right to change from an individual term insurance policy to an individual whole life insurance policy.

Coordination of Benefits (COB) Clause—A provision in a group health insurance policy specifying that benefits will not be paid for amounts reimbursed by other group health insurers.

Corridor Deductible—A flat amount that an insured must pay above the amount paid by his hospital surgical expense policy before any benefits are payable under the major medical policy. In a sense, the deductible bridges the gap between a hospital-surgical policy and a major medical policy.

Cost-of-Living Adjustments (COLA)—An increase in a benefit to compensate for an increase in the cost of living.

Cost-of-Living Benefits—A benefit providing for increases in the benefit amount if the disability lasts longer than one or two years. The benefit increases to keep up with the cost of living according to a formula stated in the policy.

Credit Life Insurance—A type of decreasing term insurance designed to pay the balance due on a loan if the borrower dies before the loan is repaid.

Current Liabilities—Short term debts and obligations that must be paid within a year.

Date of Issue—The date (day, month, year) on which the policy was issued.

Death Benefit—The amount payable to a beneficiary according to the policy terms upon the death of the insured.

Death Claim—When the insured dies, the person(s) entitled to the proceeds must complete certain insurance company death claim forms giving proof of death and establishing claimant's right to policy proceeds. When filed with the company, the company is said to have a death claim.

Debit—Refers to a marketing system of going door-to-door and collecting premiums or to the total premiums which the agent is to collect on policies in force in his territory. See also Home Service and Industrial Insurance.

Decedent—The one who is dead.

Declination—The rejection by a life insurance company of application for life insurance, usually for reasons of the health or occupation of the applicant.

Decreasing Term Insurance—Term life insurance with a face value that will decrease each year over a stated period of time. It may be purchased as a single contract or as a rider to another type of policy.

Deferred Annuity—An annuity contract providing for the income payments to begin at some future date.

Deferred Group Annuity—A type of annuity providing for the purchase each year of a paid-up deferred annuity for each member of an employee group. The amount received by an employee at retirement is the sum of these deferred annuities.

Delivery of Policy—The receipt by the insured of the insurance contract.

Disability Income Insurance—Insurance that provides a benefit to replace a portion of an individual's earned income in the event that the insured is too sick or hurt to work.

Disability Waiver of Premium—A policy rider providing for the automatic payment of premium by the company should the insured become totally, physically incapacitated. It extends through the period of disability only and usually is offered to age 60.

Dividend—The return to the policy holder of part of the premium paid for a policy issued on a participating basis by the insurer. It represents an excess of collected premiums over expenses, actual mortality, and investment experience during a period of time. Dividends may be used by the policy holder: (1) as cash refunds; (2) to reduce the next premium; (3) to be kept at interest by the insurer; (4) to purchase paid-up life insurance; and (5) to purchase one-year term up to the amount of cash value in the policy.

Dividend Accumulations—Amounts that result when a policy owner leaves the policy dividends owed on deposit with the insurer.

Dividend Addition—An amount of paid-up insurance purchased with a policy dividend and added to the face amount of the policy.

Dividend Options—Several alternatives that participating policy owners can choose from to indicate the manner in which they want to receive their dividends.

Double Indemnity—See Accidental Death and Dismemberment.

Duplicate Policy—A replacement policy or certificate issued by the company when the original policy is lost or destroyed.

Effective Date—The month, day, and year on which the insurance under the terms of the policy begins.

Elimination Period—The number of days after a disability occurs before policy benefits become payable.

Employee Benefits—Those programs in addition to salary offered to an employee. In the area of insurance they include mainly life and health insurance as well as pension plans.

Endorsement—A change made to an existing policy. Usually additional coverage is added or some part of the existing coverage is eliminated. It becomes part of the policy.

Endowment—Cash from life insurance payable to the policy holder, if he is still living at the policy maturity date.

Errors and Omissions Insurance—A type of professional liability insurance which indemnifies life insurance agents among others for losses caused by their errors or oversights in the conduct of their business.

Estate Planning—An analysis and procedure designed not only to provide funds for the prospect's dependents upon the death of the prospect, but also to conserve, as much as possible, the personal assets the prospect wants to bequeath to heirs.

Estate Tax—A tax imposed upon the right of a person to transfer property at death. This tax is imposed by the Federal government and by many states.

Evidence of Insurability—Any statement or proof of a person's acceptability for the issuance of insurance protection.

Exclusion—Specified conditions or circumstances for which the policy does not provide benefits.

Executor—The person or corporation appointed by the court to carry into effect, or execute, the provisions of a will. The court will appoint the person named in the will of the deceased as executor, provided that the person consents and qualifies. See Administrator.

Expiry—A policy or benefit rider which has reached the end of its specified period of coverage. Sometimes used to refer to the end of the premium payment period.

Extended Term Insurance—A nonforfeiture option that uses an ordinary life policy as a single premium to purchase term life insurance in the amount of the original policy.

Face Amount—The sum of money as stated on the face of the policy that will be paid in the event of the death of the insured or at the maturity of the policy. It does not include additional amounts payable under accidental death or other special provisions, nor those acquired through the application of policy dividends. It will be reduced at payment by an outstanding policy loan.

Face of Policy—The first page of the insurance policy containing the essential elements of an insuring agreement between the insurer and the insured.

Family Income Policy—A life insurance policy combining ordinary life and decreasing term insurance. The beneficiary receives income payments to the end of a specified period if the insured dies prior to the end of the stated period, plus the face amount of the policy. The face amount is paid either at the beginning or end of the income period.

Family Policy—A life insurance policy providing insurance on all or several family members in one contract. Generally this includes whole life insurance coverage on the principal insured and smaller amounts of term insurance on the spouse and children, including those born after the policy is issued.

Fifth Dividend Option—The use of the policy's dividend (or part thereof) to purchase one-year term insurance.

Flexible Premium Policy or Annuity—A life insurance policy or annuity under which the policy holder or contract holder may vary the amount or timing of premium payments.

Free Look—A notice written in the contract to the policy holder that the company provides a given period of time (usually 10 days) in which to examine the policy after delivery and return it for a refund of premium.

Future Increase Option—An option which allows the insured to buy additional monthly benefit amounts without proving medical insurability.

General Agent (GA)—The individual in charge of a field office of an insurance company that uses the general agency distribution system. The general agent is an independent entrepreneur who is under contract to the insurance company.

Grace Period—The period of time, typically 31 days, following the premium due date during which the insurance remains at full benefit and payment of the premium may be made without penalty.

Group Annuity—A contract providing retirement annuity benefits to a group of persons under a master policy, usually issued to an employer.

Group Insurance—Insurance written on a group of people under a single master policy, issued to their employer or other entity, usually providing life and health insurance.

Guaranteed Convertible—The promise that a policy may continue at the current face value under another form of insurance at the new premium without underwriting by the company. Usually conversion is offered in term policies for permanent insurance.

Guaranteed Cost Insurance—Policies issued with all cost factors for the future guaranteed at the time of issue.

Guaranteed Insurability Option—A provision or rider to a policy allowing the purchase of additional insurance at specified future dates without evidence of insurability.

Guaranteed Renewable Contract—Policies in which coverage is guaranteed to a specified age, as long as premiums are paid. Premiums may not be changed unilaterally or on an individual contract. The insurer can change the premium by underwriting class.

Health Insurance—Medical expense insurance pays the insured's hospital, surgical, doctor and related expenses. Disability income insurance is included. Both generally pay for losses arising from sickness or accident.

Health Insurance Benefits—Those benefits in a policy which are payable as the result of a covered accident or sickness.

Home Office—Principal office of an insurance company where the chief executive and general supervisory departments are located.

Home Service Insurance—A term referring to the method by which premiums are collected. Usually the agent collects the insured's premium at the home or place of business on a monthly or sometimes weekly basis. Formerly called debit insurance. Some companies specialize in this type of client service.

Hospital Benefits—An insurance benefit providing payment for covered hospital expenses.

Hospital-Surgical Expense Insurance—A type of health insurance that provides benefits related directly to hospitalization costs and associated medical expenses incurred by an insured for treatment of a sickness of injury.

Immediate Annuity—An annuity contract providing for the first payment of the annuity to commence following the initial payment of the funds to purchase it from the company.

In Force—A policy on which premium payments are either up to date or not in arrears beyond the grace period.

Initial Premium—The first premium paid by the applicant for new insurance.

Incontestable Clause—The provision of a policy preventing the insurance company from declaring the contract invalid after a certain date, usually two years as established by the individual states.

Indemnity—Benefits of an insurance contract paid in a pre-determined amount in the event of a covered loss.

Individual Retirement Account (IRA)—A popular tax-deferred, individual retirement plan that can be established by anyone with earned income.

Inspection Report—The report a company receives from an independent investigator giving general information on the health history, occupation, financial status, and moral problems of an applicant.

Insurability—Those qualifications of age, health, occupation, and so forth that enable the proposed insured to meet the requirements of a company for the issuance of insurance.

Insurable Interest—An underwriting test for application of insurance that demonstrates the person who purchases a policy has an interest in the continued longevity of the insured.

Insurance—The contractual relationship that exists when one party, for a consideration (premium), agrees to reimburse another for loss caused by the designated contingencies.

Insurance Age—An age upon which current premium rates may be established. It is commonly based on age at last birthday, age at next birthday, or age at nearest birthday.

Insurance Commissioner—The state official who enforces the state government's regulations and codes governing the operations of both companies and agents licensed to do business in the jurisdiction.

Insurance Department—A government department in each state or territory charged with the supervision and licensing of insurance companies and agents and the general administration of insurance laws or codes.

Insurance Examiner—The representative of a state insurance department assigned to participate in the official audit and examination of the affairs of an insurance company.

Insurance Policy—A written legal document issued by an insurer setting forth the terms of the coverage and the rights and obligations of each party under the contract.

Insured—The person whose life is protected by the insurance policy.

Insurer—The party of the insurance contract promising to pay the losses and benefits. The term is also used to refer to the company providing insurance to the public.

Interest Option—A life insurance settlement option under which the proceeds of a policy are temporarily left on deposit with the insurer and the money earned on those proceeds is paid annually, semiannually, quarterly, or monthly to the beneficiary or other payee.

Interest-Sensitive Insurance—A general category of insurance products in which the face amount and cash value vary according to the insurer's investment earnings. In investment-sensitive insurance products, policy owners share a portion of the insurer's investment risk. The exact benefit amounts for these policies cannot be computed in advance, beyond any guaranteed minimums. The specific products that make up this category of insurance include variable annuities, variable life insurance, and variable universal life insurance.

Irrevocable Beneficiary—The beneficiary designation in a policy that cannot be changed without beneficiary permission or at the death of the beneficiary.

Issue Limits—The maximum benefit the insurer will write for a given insurable income amount.

Joint and Survivor Annuity—An annuity under which the series of payments is made to two or more annuitants and the payments continue until both or all of the annuitants have died.

Key-Person Insurance—Life insurance purchased by a business on the life of an employee whose continued participation in the business is important to the firm's success and whose death or disability would cause financial loss to the company.

Lapsed Policy—A policy terminated by a company for nonpayment of premiums within the time required. Lapsing is sometimes limited to a termination occurring before the policy has a cash or other surrender value to pay the premium.

Level Premium—A rating structure designed to keep the premium costs the same throughout the life of the policy.

Level Term Insurance—Term insurance with a constant face value from date of issue to date of expiration.

License—Certification by a state's insurance department that a company, agent or broker has the right to do business by qualification and certification with the public for a stated period of time.

Life Expectancy—The average number of years of life remaining for a group of persons of a given age according to a particular mortality table.

Life Insurance—The scientifically calculated pooling, growth, and distribution of money to satisfy two objectives: (1) paying benefits to survivors of someone who dies while covered; and (2) providing distribution of benefits by lump sum or with guaranteed lifetime payments.

Limited Payment Life Insurance—Ordinary life insurance on which premiums are payable for a specified number of years or until death, if death occurs before the premium payment period ends. Examples would be 10, 20 pay life, single premium, or life payable to age 65.

Loan Interest—The rate of interest the borrower must pay on the loan as specified in the policy. If the interest is not paid, it will be added to the loan.

Loan Value—The largest amount that can be borrowed by the policy owner on the security of the cash value of the policy without surrendering the contact.

Long-Term Disability Coverage—Coverage for disability lasting longer than two years.

Lump Sum—The method for payment of insurance proceeds of a policy where the whole amount due or still owing is payable to the beneficiary in one sum.

Major Medical Insurance—A type of medical expense insurance that pays a stipulated percentage, (often as 80-percent), of hospital, surgical, and medical bills after first deducting certain amounts.

Master Policy (Master Contract)—A policy issued to an employer or trustee, establishing a group insurance plan for designated members of an eligible group.

Maturity—The date at which the endowment amount of a life policy becomes payable.

Medical Examination—The physical examination given by a qualified physician to determine the insurability of the applicant.

Medical Examiner—A licensed and practicing M.D. appointed by an insurance company and authorized to make physical examinations of persons applying for insurance.

Medical Information Bureau (MIB)—A cooperative organization formed by life insurers to exchange information about the physical condition of prior applicants. It provides only physical and health information.

Medicare—A federal government insurance plan attached to the Social Security Act of 1965 providing a health insurance program for the aged.

Misstatement of Age—Error in birth date given at time of policy issue.

Mode of Payment, Premium—The frequency with which the annual payment of premium for an insurance policy is made. Modes include annual, semi-annual, quarterly, monthly, and weekly.

Morbidity Table—A table that statistically represents the rates of illness suffered by individuals for any given sex, age, occupation, etc. Used in health insurance premium calculations.

Mortgage Insurance—Insurance to protect the home-owning family should the breadwinner(s) die before the mortgage is retired. Customarily the benefit is used to pay the outstanding sum owed.

Mortality—The actuarially expected rate of death of people by age and category.

Mortality Table—A statistical table showing the death rate at each age, usually expressed as so many per thousand people.

Mutual Insurance Companies—Insurance companies without capital stock, owned by the policy holders. A portion of surplus earnings may be returned to policy holders as dividends.

Net Amount at Risk—The difference between the face amount of the insurance contract and the reserve.

Net Cost—Term usually used to refer to the cost of life insurance after the deduction of dividends from the premium paid for a participating policy with a mutual company. Because no dividends are paid on non-participating policies, the net cost is equal to the total premium paid.

Net Single Premium— A technical term used by actuaries in rate calculation to describe the present value of the expected benefits of an insurance policy.

Net Surrender Cost—Refers to ratio in a policy of premiums minus dividends minus cash surrender value at the end of a specific period.

New Business—New insurance policies written for which applications are still in the process of being issued by the home office.

Noncancellable and Guaranteed Renewable—Policies in which coverage is guaranteed to a specified age or for a specified time as long as premiums are paid. The insurer cannot refuse to renew the policy, change the premium, or change the policy provisions.

Noncontributory—A term used to describe an insurance plan in which the employer pays the employees' cost for protection.

Nonforfeiture Options—The various ways in which a policy owner may apply the cash value of a life insurance policy if the policy lapses.

Nonmedical Limit—The maximum face value of a policy that a company will issue without the applicant providing further medical history by examination.

Nonparticipating Insurance—Insurance on which no dividends are payable, generally associated with the insurance contracts offered by stock insurance companies. Insurance written for a fixed premium without provision for dividends to insureds.

Not Taken Out (NTO)—The term used to describe a policy that has been returned by the agent or policy holder or when the initial premium is not paid by a given date after policy issue. The policy is not accepted by the policy holder.

Offer and Acceptance—As applied to life insurance, the "offer" may be made by the applicant through the signing of an application, submitting to a physical examination and pre-payment of the first premium. Policy issuance, as applied for, then constitutes the "acceptance" by the company. Also, the reverse may the true when the "offer" is made by the company by underwriting an application where no premium payment has been submitted. Premium payment at the delivery of the policy constitutes the "acceptance" by the applicant.

Ordinary Life Insurance—The most common form of basic permanent life insurance in which coverage and premiums are paid to age 100. The policy is designed to build cash values equaling the face amount at age 100.

Original Age Conversion—Changing a term life insurance policy to a whole life policy at a premium rate based on the age of the insured at the time the term policy was purchased. (See attained age conversion.)

Overhead Expense Insurance—A type of disability insurance designed to help the business owner offset the cost of rent, utilities, employees' wages and auditor's fees during a covered period.

Own Occupation—A liberal definition of total disability; generally as being "unable to perform the important duties of your regular occupation." Sometimes known as regular occupation.

Paid-Up Additions—Units of single premium insurance purchased with dividends of participating policies. One of the customary dividend options.

Paid-Up Insurance—Insurance on which all required premiums have been paid. The term is frequently used to indicate the reduced paid-up insurance available as a nonforfeiture option, but can also be applied to any policy meeting the requirement.

Paramedical Examination—The physical examination of an insurance applicant by a trained person other than a physician.

Partial Disability—The inability to do some of the specific duties relating to a job or profession.

Participating Insurance—Insurance on which dividends may be payable to policy owners as determined by the company's board of directors.

Payroll Deduction Insurance—Employer authorized deductions from salary earnings of an employee in amounts to cover the premium of individual life of disability income insurance policies. The employer forwards the premium to the company on a billing statement. (Also known as salary deduction.)

Pending Claim—A description of the status of a claim for benefits during its processing stage. This refers to the time period between the date of first notice of claim being received by the insurer or its representative and the date the final determination of the insurer's liability is communicated to the claimant.

Pension Plan—An employer sponsored system for the payment of annuities or pensions to qualified individuals during retirement, frequently using insurance.

Period Certain—The specified time under a settlement option or annuity during which the insurer unconditionally guarantees that benefit payments will continue.

Permanent Life Insurance—Life insurance designed to be in force for the whole of a person's life. Refers to all insurance except term.

Persistency—The degree to which the life insurance business an agent writes stays on the books through a specified period of time (usually measured at 13 months, two years and other fixed time periods).

Placed Business—Policies that have been issued and delivered to and accepted by the policy holder, who has, in turn, paid the first premium.

Policy—The printed legal document stating the terms of the insurance contract issued to the policy owner by the company.

Policy Fee—A fixed sum charged by the insurance company to the policy holder as part of the initial premium (or ongoing premiums) to help offset the underwriting and expenses. It is included and figured into the premium to the policy holder.

Policy holder—One who owns an insurance policy. It need not be the insured. Also referred to as policy owner.

Policy holder Service Department—The department of the insurance company that services the policy holder's needs and questions after the policy has been issued and put in force.

Policy Loan—A loan made by a life insurance company from its general funds to a policy owner on the security of the cash value of a policy.

Policy Reserves—The measure of the funds that a life insurance company holds specifically for fulfillment of its policy obligations. Reserves are required by law to be calculated so that, together with future premium payments and anticipated interest earnings, they will enable the company to pay future claims.

Policy Year—The 365 or 366 days between annual premium dates. The year commencing with the effective date of the policy or with an anniversary of that date.

Pool—A group of reinsurers or insurers organizing to underwrite a particular risk by sharing premiums, losses, and expenses.

Preauthorized Check—One of a variety of names applied to a system whereby the policy owner authorizes the company to draw a check on his bank account to pay an insurance premium.

Pre-Existing Condition—A physical condition of the applicant existing prior to the issuance of an insurance contract.

Preferred Risk—A risk whose physical condition, occupation, mode of living, and other characteristics indicate a prospect for longevity superior to that of the average longevity of unimpaired lives of the same age.

Preliminary Inquiry Form—Also called a trial application, it is the type of application form used when there is a high probability that a policy either will not be issued or will be issued with such a high substandard rating that the policy premium will be unacceptable to the applicant. Trial applications are also used when very large face amounts of insurance are requested. Using a preliminary inquiry form usually brings a quick response from the underwriting department.

Preliminary Term—Insurance protection for a temporary period preceding the effective date of the permanent coverage.

Premium—The payment, or one of the periodic payments, a policy owner agrees to make for an insurance policy.

Premium Deposit—The cash deposit paid by an individual with application for insurance protection. It is usually at least equal to the first month's estimated premium and is applied to the actual premium due at billing.

Premium Due Date—The date specified for the payment of a premium.

Premium Loan—A policy loan made for the purpose of paying premiums.

Premium Notice—Billing of the next premium due from the policy holder to the company.

Premium Receipt—The company's official receipt given to a policy holder when the premium is paid.

Presumptive Disability—Physical condition where total disability is often assumed. These conditions can include loss of sight or hearing, loss of speech, or the loss of two limbs.

Proceeds—The face value of the policy and any increments payable at maturity, on death, or on surrender, less any indebtedness.

Production—New business sold by an agent or other sales employee.

Proposed Insured—The person on whose life the insurance policy is being applied for.

Prospect—The potential buyer who has been identified by the agent.

Provision—A statement in the policy describing a feature, benefit, requirement, or condition of the contract.

Qualified Retirement Plans—Retirement plans that are "qualified" under law to avoid or postpone taxes until such time as the person retires or otherwise begins to take benefits.

Rate—The charge per unit, usually in increments of $1,000 for life insurance and $100 for disability income insurance, used to determine insurance premiums.

Rated Policy—Sometimes called an "extra-risk" policy, it is an insurance policy issued at a higher-than-standard premium rate to cover the extra risk when, for example, an insured has impaired health or engages in a hazardous occupation.

Rebating—A sales practice wherein the agent offers the prospect a special inducement to purchase a policy. The rebate is usually made in the form of a share of the agent's commission. This practice is prohibited in most of the United States.

Reduced Paid-Up Insurance—A form of insurance available as a nonforfeiture option, providing for continuation of the original insurance plan, but for a reduced face amount as determined by the cash value in the policy.

Reinstatement—Term used to refer to a lapsed life or health insurance policy that has been restored to its original premium-paying status. Usually it requires evidence of good health and payment of past-due premiums.

Reinsurance—The name given to the process of a company placing excess insurance sold beyond the dollar limit they are willing to carry as a risk on a single life with another company. Companies may also go to a reinsuring company to share a percentage of the risk on a rated application they have received. Insurance companies reinsure their excess risks with other companies.

Reissue—A policy that has been issued, paid for, and then returned to the company for changes.

Renewable Term Insurance—Term insurance providing the right to renew at the end of the term for another term or terms without evidence of insurability. The premium rates increase at each renewal as the age of the insured increases.

Renewals—A policy is said to renew each time an annual premium is paid or completed. A "renewal commission" is paid to the agent after the first policy year. A "renewal premium" is any premium due after the first policy year.

Replacement—The substitution of one insurance contract for another.

Representations—Any statement made before, during, or after a sales interview that materially represents the policy or plan of insurance offered.

Reserve—The money set aside by a company to fulfill future obligations.

Residual Disability—Residual disability benefits provide for a replacement of earnings due to a disability which is less than total disability. The amount of benefit is determined by a ratio comparing the insured's earnings prior to disability with the insured's current earnings. Contrast this with partial disability, wherein the benefit amount is determined by the degree of disability, not how earnings are impacted.

Retention Limit—The maximum amount of insurance that an insurance company will carry at its own risk on any individual. Amounts above the retention limit are placed with a reinsurer.

Revocable Beneficiary—The named beneficiary whose rights in a policy are subject to the policy owner's right to revoke or change the designation, surrender or make loans against the cash value.

Rider—An additional provision added to a policy, usually at issue and for additional premium, to enhance or modify the benefits. These riders include, among others, waiver-of-premium, accidental death, spouse insurance, children's insurance, guaranteed insurability, etc.

Risk—Chance of loss.

Salary Deduction—(See Payroll Deduction).

Settlement Options—The several ways outlined in a policy, other than by a lump sum payment in cash, by which a policy holder or beneficiary may choose to have the contract's benefits paid.

Single-Need Selling—A sales process in which the agent isolates one of a prospect's financial needs that can be met by insurance. For example, the agent may point out to a prospect the need for sufficient life insurance to cover the education of the children.

Single Premium—The amount that would constitute the full future premium on a contract at its inception.

Split-Dollar Insurance—Life insurance funded in an agreement between someone who needs permanent insurance protection but can't pay for it, and someone else who can pay the premium—and has a reason to—but who wishes to recover the cost.

Spouse Rider—Special term insurance coverage added to a policy for the spouse of the primary insured.

Standard Risk—A person who qualifies through a company's underwriting standards and practices for insurance protection without extra rating or any special restrictions.

Status—The standing of an individual policy in terms of premium payments. For example, in force, lapsed, paid-up, etc.

Stock Company—An insurance company organized and owned by stockholders, as distinguished from the mutual form of ownership, by its policy holders.

Stop-Loss Provision—A health insurance policy provision specifying that, after the insured has incurred a specified amount of out-of-pocket expenses under the coinsurance feature, no more out-of-pocket expenses need to be paid by the insured.

Straight Life Annuity—An annuity that provides periodic payments to the annuitant for as long as the annuitant lives, but that provides no benefit payments after the annuitant' s death.

Substandard Risk—The person who, because of health history or physical impairments, does not meet the underwriting qualifications for the issue of a company's standard life or health insurance policy. The policy may be issued at "extra risk" requiring additional premium for each unit of coverage.

Suicide Clause—A standard disclaimer of life insurance policies providing that the death benefit of a policy will not be paid if the insured dies because of suicide governed by the rules of the state. Most states restrict this to, at most, two years from date of issue. If suicide occurs after legal date the full death benefit is paid by the company. If suicide occurs before the time limit expires, the company's liability is limited to a return of premiums paid.

Supplemental Major Medical Insurance—Major medical insurance providing benefits over and above those benefits paid by basic hospital-surgical expense insurance.

Supplementary Contract—An agreement between a life insurance company and a policy owner or beneficiary by which the company retains the cash sum payable under an insurance policy and makes payments in accordance with the settlement option chosen.

Surrender Charge—The difference between cash surrender value of a policy and the reserve held by the company. The charge will be higher in the early years of a policy to cover costs arising from underwriting.

Surrender Cost Index—A representation of the annual cost per $1,000 of insurance if the policy is surrendered for its cash value, taking into consideration the sum of the cash value.

Tax Deferred Annuities (TDA)—Tax favored vehicles for deferring compensation exclusively for employees of public schools or nonprofit organizations exempt from taxes under IRC (Internal Revenue Code) sections 501 (c)(3) or 403(b). Also called Tax Sheltered Annuities (TSA).

Ten Day Free Look—A policy provision notifying purchasers of new insurance that they have ten days after delivery to inspect the policy and if not satisfied, return it to the agent or company for a full refund of all premiums paid. (See also free look).

Term Life Insurance—Life insurance providing a death benefit for a limited period of time on the life of the insured and expiring without value after the stated period.

Total Disability—A disability that prevents the insured from performing any duty of his usual occupation or from performing any occupation for which the insured is reasonably suited.

Total Needs Approach—The process of dealing with all life values and needs at the same time when working with a prospect or client in the sale of life insurance.

Trusts—Arrangement by which property is held by a person or corporation (the trustee) for the benefit of others (the beneficiaries). The person who establishes the trust (the grantor) gives the trustee title to the trust assets (the corpus) subject to the terms of the agreement.

Twisting—A form of misrepresentation in which an agent induces a policy owner to cancel an insurance policy and use the cash value of that policy to buy a new policy. In the process, the agent does not fully inform the policy owner of the differences between the two policies, nor the financial consequences of the replacement. Twisting involves a misleading or incomplete comparison of the policies to the disadvantage of the policy owner. Twisting is a prohibited insurance sales practice.

Unbundled Insurance Product—An insurance product in which the mortality, investment, and expense factors used to calculate premium rates and cash values are each identified in the policy. Non-traditional products, such as universal life insurance, are unbundled.

Underwriter—The employee of an insurance company who selects the risks. The assignment is to authorize the sale of coverage that will produce an average risk of loss within an anticipated class of business.

Underwriting—The process by which insurance companies analyze risks to decide if they want to insure them, and at what rates

Underwriting Manual—A summary of the methods used by a particular insurer to evaluate and rate risks.

Uniform Provisions—Contract provisions required by state statutes, generally modeled after the National Association of Insurance Commissioners' Uniform Accident and Sickness Policy Provisions Law. In general, they set the "operating conditions" of the policy.

Unearned Premium—The part of the premium payment applicable to the unexpired part of the policy period. Usually due to the policy holder if the policy is canceled.

Uninsurable Risk—A person not acceptable to the company to qualify for insurance due to excessive risk.

Universal Life Insurance—A type of permanent life insurance under which the policy holder is allowed to vary the timing and amount of premiums as well as the death benefit. Premiums (less expenses) are credited to the policy account (cash value) from which mortality charges are deducted and to which interest is credited at a variable future rate.

Variable Annuity—An annuity contract in which the amount of each periodic income or investment payment may fluctuate. The fluctuation may be related to securities market values, a cost of living index, or some other variable factor.

Variable Life Insurance—A type of permanent life insurance in which the death benefit and the policy's cash value may vary in relation to the investment experience of the selected fund in which the cash value is invested.

Variable Universal Life Insurance—A form of whole life insurance that combines the premium and face amount flexibility of universal life insurance with the investment flexibility and risk of variable life insurance.

Vesting—A participant's ownership rights to benefits from employer's contribution to a plan and not contingent upon continued specific employment with the employer. Vesting also refers to the agent's ownership of his renewal commissions.

Waiting Period—In disability income insurance, a specified amount of time, beginning with the onset of the disability, during which benefits are not payable. Such waiting periods may last from seven days to six months. The waiting period in a disability income insurance policy is sometimes called the elimination period.

Waiver—A policy condition that excludes coverage for a specified illness, injury, or activity. Also called exclusion riders or exclusion endorsements. If a health problem is waived, the term "impairment waiver" may be used.

Weight and Height Table—A table of statistics giving information on the average weight and height of men, women and children used in underwriting for standard risks.

Whole Life Insurance—Another name for ordinary life insurance referring to premium payment for the whole period of a person's life.

Will—A document prepared by an individual in which instructions are made for the disposition of the property of the estate at death.

Workers' Compensation—Government-mandated insurance that provides benefits to a covered employee and his dependents if the employee suffers job-related injury, disease, or death.

X-Dating—Finding the expiration date of certain coverage and calling the prospect back before the date to make an offer to bid on the coverage.

Yearly Renewable Term (YRT) Insurance—Term life insurance that gives the policy owner the right to continue the coverage at the end of each year for a specified number of years or until the insured reaches the age specified in the contract. Also called annually renewable term (ART) insurance.

I. THE INSURANCE INDUSTRY, ITS STRUCTURE AND JURISDICTION

A HISTORICAL PERSPECTIVE: STATE v. FEDERAL JURISDICTION

Insurance is truly a big business. There is more than ten trillion dollars of life insurance in force in the United States. More than one hundred billion dollars of benefit payments are made each year to policy owners, beneficiaries, and annuitants. Life insurance companies in the United States have over two trillion dollars of assets. Insurance companies in the United States pay over sixteen billion dollars of taxes to state and federal governments.[1] This represents a great deal of cash and cash flow in our economy. Obviously, an industry controlling that much revenue would be a regulated one. The interesting question is who the state or the federal government should have jurisdiction over the insurance industry. This question has been actively debated for many, many years.

Case law on this debate goes back over 130 years. If insurance is defined to be "interstate commerce," then Congress has the right to regulate; if not, then the states have that authority. In 1868, in the case of Paul v. Virginia, 75 U.S. (8 Wall.) 168 (1868), it was held that insurance is not commerce. In 1944, in U.S. v. South-Eastern Underwriters Association, 322 U.S. 533 (1944), it was held that insurance **is** commerce, and basically interstate commerce at that.

Only a year later, in 1945, Congress passed the McCarran-Ferguson Act. It was entitled "An Act to Express the Intent of Congress with Reference to the Regulation of the Business of Insurance." The new law made two things clear: the business of insurance would still be subject to the laws of various states, and Congress would retain certain powers that could be exercised if, after a period of adjustment, the business was not regulated by state law. In addition, the insurance industry enjoys a limited "antitrust exemption." Federal law does not apply to the business of insurance except to the extent it is not regulated by state law. Most states have enacted laws covering rate-making, unfair trade practices, and antitrust laws for insurers and have appointed or elected state Insurance Commissioners to regulate that industry within the state; therefore, the states can, and do, regulate the insurance industry, with Congress reserving the right to step in for cause in the future.

The National Association of Insurance Commissioners (NAIC) was formed in 1871. It was originally called the National Convention of Insurance Commissioners. At that time the NAIC tried to draft and enact model laws to regulate rates, standardize policy forms, and provide for fair trade practices. Since that time, the Insurance Commissioners of the respective states have established state agencies that dictate which insurance carriers may sell products in their states, approve which products are acceptable to be sold in their states, and regulate the contracting, education and

[1] American Council of Life Insurance, 1992 Life Insurance Fact Book, Washington, D.C.: American Council of Life Insurance, 1993.

licensing of persons permitted to sell products in their states. Each and every state has its own parameters and review processes.

Has state regulation been adequate? Should the industry be allowed to keep its anti-trust exemption (specifically with respect to the sharing of claim information)? On the positive side of this exemption, companies are allowed to share statistics that small companies couldn't compile on their own. There are certain other pro-consumer practices that enable prices to come down, more accurately reflecting the risk insured. Those who argue against the anti-trust exemption speak darkly about a conspiracy to set and/or inflate prices for profits. They see a collusion against the financial interests of the consumer. Congress raises questions about federal oversight every few years. It talks about rate-setting in property/casualty companies, or abusive life insurance selling practices through the use of computer illustrations. Federal oversight might produce a better result with respect to product approvals and licensing issues. On the flip side, federal intervention sometimes creates huge backlogs and inefficiencies.

What would happen if we moved from working through fifty state insurance departments to one federal agency? Some companies would welcome federal oversight: they could deal with one agency instead of fifty. They feel many states are not adequately staffed or funded. They feel there is no continuity in decisions because of agency turnover in the states. Others are concerned about the delays, waste and inefficiencies we see in the federal government today. This is an issue that will continue to be debated. For the moment, however, we are dealing with the various states on insurance matters.

How do states regulate insurance? There are generally three bodies that have input: the courts; the legislatures; and the administrative agencies (insurance departments). The courts are charged with interpreting statutes and deciding conflicts between policy provisions and the "public good." The legislatures enact statutes and the administrative agencies draft regulations to guide people on following the statutes. The insurance departments have a number of functions: the licensing of companies, agents and brokers; the approval of policy forms and rates; company solvency issues and periodic exams; rehabilitation and/or liquidation of failed insurers; consumer complaints against companies and agents.

TYPES OF INSURANCE COMPANIES

There are three major types of insurance companies: stock, mutual, and fraternal. **Stock companies** are owned by stockholders. They exist to provide a fair return to their shareholders under a business model of providing value to customers and delivering on promises made to policy holders. At the end of the fiscal year, any profit made by a stock company and not retained in surplus to make the business grow is distributed to the owners. **Mutual companies** are owned by the policy owners. Most policies issued by a mutual company are "participating" contracts, or par contracts for short. At the end of the year in a mutual company, any gain from

operations (profit), less an amount retained in surplus to fund new business growth, is divided among the participating policies under an equitable process and paid to the policy owners as a dividend. The other companies are called **fraternal organizations**. These are organizations, usually religious, social, ethnic or vocational in nature, that provide coverage only to members of the organization. By law they must be non-profit, and any surplus generated within the year has to be distributed to the members. They are exempt from federal income tax, as well as all state and municipal taxes. They do have to pay taxes on real estate and office equipment.

You may hear the word **"demutualization"** being used. Demutualization is a process through which mutual companies become stock companies. They move from being owned by the policy owners to being owned by investors (stockholders). Why would the board of directors of a mutual company vote to do this? The main reason is that a stock company has more access to capital, which is needed to grow the business.

COMPANY FAILURES AND STATE GUARANTY ASSOCIATIONS

COMPANY FAILURES. Sometimes companies, even those with good financial ratings, fail. What happens to the policy owners and the insureds? What happens to the people who sold the policies? Typically, the insurance commissioner of the state in which the company is domiciled takes over the failed insurer and is the one who pronounces a company "failed." The insurance commissioner first decides how the policy holders will be treated, and later determines the treatment of commissions due to agents on in force policies. Some stop all commission payments entirely while others continue to pay them as a routine cost of doing business. Remember, the brokers and agencies are still servicing the policies and counseling their clients. NAILBA has been outspoken on behalf of member agencies and their brokers when renewal commissions and other compensation payments have been stopped. As with many items of this type, litigation usually provides the final answer.

STATE GUARANTY ASSOCIATIONS. In an effort to help protect insureds and the policy owners, many states (but not all) have **State Guaranty Associations:** if an insurance company has been declared financially impaired or adjudged **insolvent**, the SGA will step in to provide some measure of benefits to policy owners. The protection provided depends on the state of domicile of the insurer, as well as where the policy owner lives. Some guaranty associations cover the benefits promised by any insurer domiciled in that state; others offer protection only to policy holders who are residents of that state. In any event, the existence of these guaranty associations as a "financial backstop" cannot be advertised to potential policy holders during the sales process. You should become familiar with the provisions and guarantees of the State Guaranty Association in any state in which you do business.

If a company fails, a guaranty association collects the money it needs to support the guarantee given by assessing the other insurance company members of the association. The amount collected is capped by law, and is based on how much insurance (of the same type) the company writes in that state. The usual limit is two

percent of the premium written, but can go up to as high as four percent. If the **assessment** is particularly large, the collection can be spread over a period of years. Generally, the insurers assessed receive a premium tax reduction for these payments.

What types of guarantees are policy owners given? The coverage varies from state to state, but some general comments can be made. In many states, death benefits of up to $300,000 are guaranteed, and up to $100,000 of contractually guaranteed cash values are protected. People with amounts in excess of the protected figures are usually treated as general creditors of the failed insurer: they have to stand in line with all the other people and organizations who are owed money by the insurer. Treatment of **variable contracts** is different. The cash values are included in a separate account and are always available to the policy owners no matter what happens to the insurer. These accounts cannot be touched by general creditors. For a discussion of variable contracts, refer to Chapter III.

COMPANY REHABILITATION. Sometimes a troubled insurance company can be **rehabilitated**. The company can be reorganized under bankruptcy laws, troubled assets can be replaced by higher-rated ones (if that was a problem), and the company can start operating again. In that case people may have access to the entire death benefit or value in the contract. Sometimes another insurer will buy the failed company; again, all the assets may be protected here. Sometimes a policy owner will have to wait a number of years to have access to all the values, or forfeit some amount of interest to get the funds immediately. The insurance industry has a strong record of making policy owners whole on their contracts.

CREDITORS, BANKRUPTCY AND INSURANCE

Life insurance and annuities share a common element of savings. While life insurance has death protection as its primary benefit, it also (except for term insurance) has a cash surrender value, which accumulates tax-deferred. An important attraction of many individually-owned deferred annuities is the tax-deferred accumulation of values.

Even people who buy insurance and annuities can suffer financial reversals, including **bankruptcy** and lost **lawsuits**. Suppose a person has more liabilities than assets, and creditors (whether in or out of bankruptcy) are looking for sources of funds to recapture money owed to them. Can **creditors** pursue death benefits (paid to beneficiaries), cash surrender values or annuity values to get some or all of their money?

As with other legal issues, clients should consult with their personal advisers about their particular situation. The answer will vary from jurisdiction to jurisdiction as well. Still, some general statements can be made to show how states have tried to protect certain personal values from the claims of creditors. The following statements all

assume the contracts in question were owned by the insured (the debtor) and they were not purchased with the intent to defraud creditors.

LIFE CONTRACTS. Most states do not allow creditors of the insured to recover death benefits paid to beneficiaries. Some states limit that protection to amounts paid to spouses, children, parents or other dependents. In most instances the cash values of a life policy are exempt from attachment. Some states (a small minority) have dollar limits on the protection afforded.

ANNUITIES. Annuity values are a little different. Many states have not addressed these values by statute. Others either make the values exempt completely, or exempt a certain amount per month if the annuity is in a pay status (the contract has been annuitized).

Though neither you nor any employee of the Agency should be drawn into a position of recommending one state over another state (as the best place for a contract to be issued because of the existence of a favorable statute), it is appropriate that you be aware that differences do exist state by state. If you are questioned about such differences, you should refer the client to his personal legal advisor.

II. INSURANCE COMPANY INVESTMENTS AND COMPANY RATINGS

INSURANCE COMPANY INVESTMENTS AND HOW THEY ARE DIRECTED

Insurance companies in the United States and Canada hold and invest close to three trillion dollars of **assets.**[2] **These assets, directly and indirectly, contribute to economic growth in these countries. They fund shopping malls, apartment complexes, industrial factories, even individual homes. The investing of these assets creates jobs in the economy.**

These investments are also critical to the insurance companies, their policy holders and their stockholders. The earnings on these investments form a significant piece of the gross revenue of insurance carriers. About 27 percent of the gross revenue of the companies comes from investment earnings, with the balance being from premiums and annuity considerations.[3] Investment earnings are first and most importantly directed toward fulfilling contractual obligations to policy holders. Companies can use excess investment earnings to pay dividends to policy holders, to pay dividends to stockholders, to reduce the price of certain products, to give a better return on existing policies (through excess interest crediting), to add to surplus or capital for growth, or some combination of all these things.

Insurance companies handle a great deal of money, often for a long period of time. That raises many questions:

- Who decides how all those dollars are invested?
- Is there some supervision on the investment process?
- Do companies treat certain obligations differently from others?
- Do all companies treat policy holders the same way when crediting "excess interest" to policies?
- How can a person tell if a company's investment practices are "safe?"
- How about all the rating services we hear about: what are they, and what do the ratings mean?
- What happens if a company cannot meet its obligations?
- Who protects the company, and who looks after the insureds and policy holders?

WHO DOES THE INVESTING? Investing for an insurance company can be handled either by company employees or by an outside firm. If a particular company is a subsidiary of a larger organization, it may be that the investments are handled elsewhere within the organization, by a sister or parent company, to thus create some economies of scale. The investment policy of a company is usually established by an investment or finance committee. This is a group appointed by the board of

[2] A.M. Best Company. 1994 Best's Insurance Reports. Oldwick, New Jersey. 1994.

[3] American Council of Life Insurance. 1992 Life Insurance Fact Book. Washington, D.C.. 1993.

directors, and consists of members of that board along with key financial figures from the company. Such participants may include the president, the head actuary, the chief investment officer, and the chief financial officer, among others.

THE INVESTMENT COMMITTEE. What kind of direction does the **investment committee** give the company? In a nutshell, very broad guidance. They usually approve guidelines established by company management. These guidelines take into consideration the long-term obligations to policy holders. Some companies even have staff economists to help predict future investment trends. The committee has to establish the kind of risk the company is willing to assume in its investment posture. Generally, the riskier the investment, the greater the anticipated return. The insurance company has to walk a very fine line here to maximize returns while managing the risk to an acceptable level. Most companies hope to be around for a long time, and therefore keep a relatively conservative risk profile.

STATE DIRECTION. There is another kind of "investment direction" of which you should be aware. Regulators and state legislatures impose limitations on the investment practices of companies licensed to do business in that particular state. The consensus is that New York has the most stringent regulations. Companies are severely limited in the amount of equity investments (stocks) they can hold. The majority of investments are held in bonds, mortgages, and real estate.

NAIC DIRECTION. **The National Association of Insurance Commissioners (NAIC)** assigns ratings and classifications for bonds which all insurance companies must abide by in the filing of their financial statements with the state insurance commissioners. The NAIC requires that all companies categorize their bonds into one of six classes. NAIC rating Class 1, representing the strongest of investments, closely corresponds to Standard and Poor's ratings (see the later discussion) of AAA, AA, and A. Rating Class 2 bonds are considered to be of investment grade and correspond to S&P's BBB rating. Rating Class 3 bonds are of medium grade, Classes 4 and 5 are of lower grade, and Class 6 holdings are in or near default. Below and including Class 3 bonds are considered by the NAIC to be "below" investment grade holdings.

The NAIC recommends that insurance companies limit their investments in bonds lower than Class 2 to 20 percent of the company's assets. The NAIC further refines its recommendations to include a 10 percent limit on Class 4 bonds, a 3 percent limit on Classes 5 and 6 bonds combined, and a 1 percent limit on Class 6 holdings.

LIFE INSURANCE RESERVES

Life insurance contracts are long-term obligations of the insurance company to the policy owner. If the premium is paid, the company must pay benefits at the specified time or event (e.g., death, disability or surrender/loan). These future benefits are a current liability for the company: they could occur at any time. In all cases, the vast

majority of a company's assets are earmarked for the satisfaction of these long-term obligations. This portion of a company's assets is called **reserves**.

Life Insurance is commonly sold with a level death benefit over a long period of time and level, periodic premiums. Claims however are more likely to occur in later years, with the insured is older, than in the policy's early years. Companies set aside, or *reserve*, some money in the early years, plus some of the investment earnings on those monies, to supplement the premiums in the later years and pay all the claims. So policy **reserves** are the company's liability for future policy obligations and a large proportion of a company's assets are earmarked to cover the reserves.

Companies use different reserve calculations for different purposes. State regulators generally require companies to use conservative assumptions when calculating Statutory Reserves. On the other hand, Tax Reserves used to determine a company's taxable income may use less conservative interest assumptions. Stock companies and some mutual companies also report reserves under Generally Accepted Accounting Principles (GAAP). GAAP Reserves incorporate more of the actual expenses in the reserve calculation and use more realistic, but still prudent, assumptions.

Insurance companies also have normal business liabilities such as debts and amounts due but not yet paid.

Assets of a company in excess of the amount of total reserves and other obligations are called a company's **surplus**. In the first policy year with many types of policies, the level of the reserve combined with the costs associated with underwriting, commissions, and administration exceed the first year premium. Hence, some surplus is used to "put the policy on the books."

Sometimes a company in an aggressive growth mode may not have enough surplus to fund that growth. Help can come from selling more shares (in a stock company) or by going to a **reinsurance company** that might provide some surplus relief by keeping reserves on its books instead of the writing company's books. A reinsurance company is an entity that sells insurance to the insurance company. It assumes part of the risk on a life in return for part of the premium.

REGULATION XXX. During the 1990's the National Association of Insurance Commissioners (**NAIC**) became concerned about statutory reserve levels on term and universal life policies with long-term guarantees. The reserve calculation methods at that time did not produce adequate reserves for these long-term guarantees so in 2000 they implemented Regulation XXX that changed the calculation method but retained very conservative mortality assumptions. The resulting reserves are generally higher than the premiums themselves can fund. Regulators and insurers are working together now to change both the methodology and assumptions to produce reasonably conservative reserves under a concept known as Principles-Based Reserves.

LIFE INSURANCE RATINGS

Brokers come to a Brokerage General Agency for help with a particular case. They might be looking for a certain product type, have a premium goal, need an underwriting quote, or ask to see a special program that an insurer might offer, such as an exchange program from term to permanent coverage. Often you will tell the broker about a company and the broker will ask you about their rating. What does that question mean, and why would the broker ask it?

There are several services that rate the financial health of an insurance company. These services include:

A.M. Best Company
Fitch
Standard & Poor's
Moody's Investors Service
Weiss Research

These services rate the ability of an insurer to meet its financial obligations under a variety of circumstances and make judgments as to the relative financial strength of the insurance company using set parameters. Each service has slightly different ways of rating insurers with different rankings.

An A.M. Best rating is provided for almost every insurer, while companies have to pay a fee to obtain certain other ratings. There is usually a lot of contact during the year between a rating organization and an insurer, and ratings may be modified during a year due to earnings results, significant corporate changes (sales, purchases, mergers), or any other change that might affect the ability of the company to meet its obligations; for example, a change in the quality of some of the company's assets.

WHAT DO THE SERVICES "RATE"? Each rating organization looks at different measures of a company's strengths and weaknesses.

- **A.M. Best** gives an opinion regarding the company's financial strength and ability to meet its contractual obligations.
- **Standard & Poor's** looks at a company's claim-paying ability. This is designed to help consumers determine if a company will meet the terms of its policy holder obligations.
- **Moody's Investors Service** gives its opinion regarding a company's ability to discharge its policy holder obligations and claims.
- **Fitch** gives its opinion as to the likelihood of contractual payments being made.
- **Weiss Research** looks at insurers in two scenarios: current economic conditions, and in a declining economy.[4]

[4] A.M. Best Company. Best's Insurance Management Report. Oldwick, New Jersey. February 19, 1992.

THE "GRADING" SYSTEM. There are many similarities to how these rating services assess the financial strength of insurers, however their "grades" are very different: An "A+" rating from Best is the second highest rating, and is considered "Excellent." Conversely, an "A+" rating from Fitch is the fifth highest category, and is not considered "Excellent." A list of how each rating service ranks a company is helpful and can be found below, but remember, not all insurers are rated by each service, and the same grade (for example, A+) can mean very different things from different services.

The ratings, from top to bottom, of the various services are:

A.M. Best	A++,A+,A,A-,B++,B+,B,B-,C++,C+,C,C-,D,E,F
Weiss	A+,A,A-,B+,B,B-,C+,C,C-,D+,D,D-,E+,E,E-,F
Standard & Poor's	AAA,AA+,AA,AA-,A+,A,A-,BBB+,BBB,
Fitch	BBB-,BB+,BB,BB-,B+,B,B-,CCC+,CCC,CCC, CC/C,DDD,DD/D
Moody's	Aaa,Aa1,Aa2,Aa3,A1,A2,A3,Baa1,Baa2,Baa3,Ba1,Ba2, Ba3,B1,B2,B3,Caa1,Caa2,Caa3,Ca

RISK BASED CAPITAL RATIOS. A relatively new measure of insurance solvency is **risk-based capital (RBC)**. This is a tool developed by the National Association of Insurance Commissioners to measure the level of capital adequacy.

The formula breaks down "risk" into four major categories:

- C-1: asset-default risk
- C-2: insurance risk
- C-3: disintermediation/interest-rate risk
- C-4: miscellaneous and external event risk

These factors are used to determine a minimum required level of capital for a company. The RBC ratio compares the company's actual capital to this minimum level.

The NAIC has cautioned the public and the industry not to use these RBC ratios to rank and judge companies on their financial safety. The ratios are really intended to aid state insurance departments in their solvency regulation efforts. These ratios are supposed to be warning signs, not absolutes. They do not take into account, for example, the quality of the management team or the sales direction of the company.

HOW TO USE AND VIEW THE RATINGS. When a broker is selecting a company with whom to place a case, several questions arise, such as:

- Does the company offer the correct type of insurance plan?
- Can the company price and underwrite the case on a favorable basis?
- Is the company financially stable and strong?
- If all these points are equal, then what level of compensation will the broker receive for writing the case?

The ratings provided by these services are sometimes seen as a shortcut **due diligence** process for the broker and the brokerage agency. Agency management should be able to talk to people at the highest levels in an insurance company to get a personal comfort level about the insurer and its investment practices and philosophies. The broker will need to assure the client (and sometimes the client's other advisers) that the insurer is viewed as financially stable by one or more of the rating agencies. No individual can access or analyze enough information on a company to make that determination independently.

When a broker asks about the financial condition of an insurer, he/she should be provided with copies of financial reports from the company and reports generated by the rating agencies. It is totally out of the expertise of an agency employee to make personal financial judgments or recommendations regarding an insurer's solvency to a broker or to the broker's clients. Areas requiring such a complex analysis to render an opinion should be left to the financial experts. The rating services and the insurance companies' own financial reports provide the best picture of a company's financial status.

III. INSURANCE PRODUCTS AND THE NEEDS THEY FULFILL

THE NEED FOR INSURANCE

Once a broker has determined a need for life insurance through fact-finding with his client, the correct product should be identified. Listed below are some typical needs for life insurance:

- Family protection to provide, for example, cash for living expenses, education funds and/or emergency funds
- Liquidity for payment of state inheritance and federal estate taxes
- Business protection against the loss of a key person's contributions to the firm
- Funds to collateralize and perhaps pay off outstanding business or personal debts
- Liquidity to purchase a business interest from a shareholder's beneficiaries
- Funds for a charity, religious organization, school or other such group

Every need can be identified as either temporary or permanent (for example, illness versus death), and an appropriate insurance product should be selected to accomplish that goal. It is important to understand the many possible product choices. There are **many kinds of insurance**, meeting a variety of needs for premium commitment, duration, value growth, flexibility and the like. Usually the broker will come to the agency and request a certain kind of policy; he or she may even specify the carrier to be used. In other instances the broker will say how much premium the client can afford, or for how many years the coverage is needed; now you are more of a detective, looking through all the products to find the "right" one. In addition, there may be objectives to take loans or partial surrenders of cash values from the contract, and issues such as potential taxation and possible loan interest treatment also become relevant.

INSURANCE PRODUCTS

SETTING THE PREMIUM. Before you can understand the differences between products, it is important that you have knowledge of what goes into setting a premium. Among the factors considered by actuaries (those people responsible for product design and for maintaining the company's sound financial basis) when they develop rates are: mortality, interest rates, expenses and lapse assumptions.

Mortality rates are statistics dealing with the frequency of death in a defined group of people. If you want to know how many 45 year old nonsmoking males in supposed good health will die in a given year, there are mortality studies to provide some estimates. Companies have to determine what **interest rate** they can earn on their investments. Remember, since a life insurance contract is a long-term arrangement, guaranteed interest rates are conservatively estimated. Among the **expenses** incurred by a company are development costs, distribution costs, administrative costs, and selection costs. **Lapse assumptions** deal with the number of policies that

will terminate during a year due to nonpayment of premium or surrender of a policy for its cash value. Companies cannot afford to incur the expenses of writing policies if a large number of them will lapse shortly thereafter. Thus, the actuaries look at both company and industry experience to make a reasonable lapse projection. All these factors are used to determine the product's price.

THE PRODUCT PICTURE. Given all the many different product types, selecting the right one can be a confusing task. By organizing products into categories, we can simplify the selection process.

First, all life contracts can be either **participating** (usually issued by a mutual company and projecting dividends), **non-participating** (usually issued by a stock company), or **variable**. It is worth noting that a mutual company can also issue a contract that does not anticipate paying dividends, and a stock company can issue a dividend paying contract.

Contracts will typically be either **term insurance** (coverage for a set number of years) or **permanent insurance** (which provides coverage for life). The permanent plans covered in this chapter will include:

- **Par whole life** (pg. 101)
- **Non-par whole life** (pg. 101)
- **Excess interest whole life** (pg. 102)
- **Universal life** (pg. 102)
- **Variable life** (pg. 104)

All of the above products are offered in contracts issued on a **single life** (i.e., the death benefit is paid upon the death of one person) or on **joint life** assumptions. Specifically, in the last case, underwriting would be done on more than one person, dual mortality assumptions used, and the death benefit paid either on the first death (**joint first-to-die**) or on the second (**survivorship** or **second-to-die** insurance).

Besides taking the basic plan types and using them in either single or multiple life situations, products are differentiated based on the type of underwriting done. An insurance product may require **full underwriting**, a form of **simplified underwriting (requires a minimum number of lives typically)** or even no (**guaranteed issue usually large groups**) underwriting. Of course, product pricing would have included consideration for the type of underwriting to be done, with higher claims expected in the policies with no underwriting required at all.

The following discussion of products may not tell you all you ever wanted to know and understand about life products, but when combined with the discussion provided in Quick Start, it will give you a general basis of information from which to work.

PARTICIPATING CONTRACTS. **Participating (par) life policies** may be either term or permanent. These policies are generally issued by mutual companies and contain a non-guaranteed **dividend** element that allows the policy owner to share in the experience of the company to the extent the experience is more favorable than what is guaranteed.

A participating whole life policy contains a fully guaranteed basic policy element as well as the dividend element. In the basic policy a guaranteed death benefit is supported by a guaranteed premium. The premium is level and guaranteed and is determined for each issue age, sex and risk class. There are some policies with modified premiums, sometimes called Mod Whole Life, where the guaranteed premium is lower at issue and later steps up to a higher guaranteed level cost.

The dividend is legally recognized as a return of premium overpaid in the policy and is not taxable as income to the policy owner unless the sum of dividends exceed premiums paid. Dividends are determined by company formula and are composed of three pieces: mortality, expenses and interest. The **mortality** piece allows the policy owner to participate in the difference between guaranteed and experienced mortality. The **expense** piece may return part of the expense charge in the premium if the company has operated efficiently. The **interest** piece allows the policy owner to participate in the company's earnings beyond the interest rate guaranteed for the basic policy cash value. This interest part of the dividend is expressed as a rate of interest, which can change each year, called the "dividend interest rate."

There are many ways in which dividends can be used and/or accessed, including:

- Dividends can be paid to the policy owner in cash each year.
- Dividends can be used to reduce the premium outlay in the contract.
- Dividends may be left on deposit with the company and earning interest (interested earned under this method is taxable in the year received, not an efficient way to take advantage of the tax leverage in life insurance polices).
- Dividends can be used to purchase paid-up additions, which are similar to small single premium policies with their own death benefit and cash values.
- Dividends can also be used to build up the death benefit by purchasing a combination of term insurance and paid-up additions.

A frequently used and very efficient use of dividends is to purchase paid-up additions for a number of years and change the dividend election to reduce premiums and/or surrender paid up additions to suspend future policy premiums.

NON-PARTICIPATING CONTRACTS. **Non-participating (non-par) contracts** are those which do not share in the profits of the issuing company. There are no dividends associated with these contracts. Usually they are issued by stock companies. Instead of crediting dividends on these contracts, the company will often credit **excess interest** (over the contractual guarantees) to these policies. This is where we find the genesis of universal contracts and excess interest whole life plans. These

non-par contracts come in all varieties, but you will most often see **term, universal and excess interest contract**s under this heading.

Non-par whole life comes in many forms. In addition to the more popular products in today's market which share the company's favorable returns in the form of excess interest, there are whole life products which feature guaranteed premiums, cash values and death benefits and no excess interest. These straightforward products are still available and you will need to recognize and service those inforce.

EXCESS INTEREST WHOLE LIFE (EIWL). This non-par policy provides permanent protection at competitive premiums. The moniker of "whole life" was attached since this coverage was designed to protect for the whole of a person's life, usually to age 95 or 100. This contract series provides a guaranteed rate of interest to be applied to policy values. The insurance company can credit a higher interest rate than the contractual guarantee, but does not promise to do so. The contract also features current mortality charges and a schedule of maximum mortality costs.

EIWL products usually fall into one of two types. There is a low-cost version with premiums set to make the contract **endow** (face amount equals cash values) at age 100 based on current assumptions. This means premiums are calculated using the current interest rate of the company and current mortality. The contract **redetermines** after a given number of years. This means the insurance company periodically examines the contract to see if the values are growing sufficiently to allow the endowment to take place. If the contract is performing as predicted, the premium stays the same. If, for example, interest rates have been higher than expected, the premium will be lowered. If interest rates have been lower than expected, premiums will be raised. Every few years the contract will redetermine, and the premium may be adjusted up or down.

The other major type of policy featuring excess interest has a higher guaranteed premium. Here the excess interest and the higher premium combine to produce high cash values. Once there is enough value in the contract to allow future cost of insurance and expense charges to be made against the values, premium payments may be suspended, and the premiums are said to have "vanished." There is not usually a guarantee of this vanish; premiums might have to be paid again in the future if interest rates fall.

Often these contracts are specifically designed for the impaired risk marketplace, and allow the same premium to be paid for a person who is preferred or for a person who is Table 8. The rated person, although paying the same premium, will pay for more years. Since the preferred person has a lower cost of insurance charges coming out of the contract, values will build more quickly, and can "vanish" sooner. Some universal life contracts are designed to do this as well.

UNIVERSAL LIFE. Universal life contracts are non-par policies that allow consumers a look at the components of a life insurance contract. There is premium flexibility, adjustable death benefits, and values that vary based on the current interest rates

credited to the policy. As with Excess Interest Whole Life, there is an interest rate guaranteed in the contract and a current rate credited to the values.

Universal life has the potential of offering a policy owner great flexibility. The premium can be any number between the **minimum premium** (required by the insurer to keep the contract in effect) and the **guideline premium** (the limit established by the Internal Revenue Code to maintain taxation as a life insurance contract). The death benefit can be a level amount, an increasing one based on cash value growth, an increasing one based on initially underwritten inflation increases, or one that decreases based on a schedule.

The contract usually allows for **borrowing** and **partial withdrawals**. These are two different ways of accessing cash value growth, but with a big difference. In most cases, the death benefit is reduced by the amount of cash taken out of the contract. If a loan is made, interest is charged on the loan each year, but the loan balance can be repaid at any time and the death benefit will be restored. If a withdrawal is made, there is no interest charged, but the death benefit cannot be restored without **evidence of insurability**. The withdrawal feature is an important advantage of universal life over whole life plans. The only way to access cash in a whole life plan is through policy loans or a surrender of dividend purchased additions. You should be aware that there are possible tax consequences for withdrawals over that amount.

TERM INSURANCE. **Term insurance** is pure protection (death benefit only) for a limited period of time for a relatively small premium. Because of this lower cost, compared with permanent coverage, term coverage builds no permanent values. Term has many forms. A popular early version was **YRT (Yearly Renewable Term)** which featured annually increasing costs. While that option is still available on a limited basis, many companies are now selling term with **level premiums** guaranteed for a certain number of years (five, 10, 15, 20, or 30). Some companies guarantee only the first year's premium, with the balance of the premium projected, but not guaranteed, to be level.

Most term coverage is **renewable and convertible**. The company promises to renew or keep in effect the coverage each year at a cost no higher than that shown in the contract, and the insured always has the right to convert for a set period of time (switch without evidence of insurability) to a higher premium permanent plan offered by the company.

Length of the conversion period should be an important part of your discussion of term with your client. Product offerings for conversion should also be reviewed.

Different types of term contracts include:

TERM TO A GIVEN AGE: Some companies provide term to a certain age (often age 65) that can help meet needs over a person's working life.

DECREASING TERM: Term coverage with a face amount that reduces over time, this can be used to cover any decreasing obligation that is paid off over a fixed period, such as a mortgage or personal loan.
INCREASING TERM: Term coverage in which the face amount increases by a certain percentage or fixed dollar amount to allow for inflation or increasing needs.
RE-ENTRY TERM: Re-entry term allows the insured to re-qualify, through the underwriting process, for a lower rate after a specified number of years. If the person does not qualify for the lower rate, he continues with the original premium schedule.

Return of Premium Term

UNIVERSAL TERM. Though earlier discussions stated that term builds no values within the contract, there is an exception. A universal life (permanent) contract may be designed to simulate term coverage. There is generally a guarantee of cost of insurance rates for the specified term period (five, 10, 15, or 20 years). During the contract, the client knows the minimum and maximum amount he can pay and still maintain the desired coverage. The product is designed to produce minimal cash accumulation at the end of the guarantee period, but there is some growth in the interim. If the clients want to make additional deposits, they can do so because it is universal life coverage. These extra payments build additional values and can reduce the amount of premium required in the future to maintain the policy after the guarantee period.

VARIABLE LIFE. Unlike the other products described in this manual, **variable products** are not solely regulated by state insurance commissioners, nor may they be sold by agents licensed as life agents only. Variable products are regulated by the **SEC** (Securities and Exchange Commission) and require special **NASD** (National Association of Securities Dealers) licensing to sell them.

More and more insurance brokers and Brokerage General Agents are becoming involved in the distribution of variable products, therefore a discussion of variable life is important for informational and competitive reasons.

In general, a permanent life insurance contract is an agreement between the contract owner and the insurance company. If the owner pays the premium, the company promises to keep the contract inforce, maintain some level of death benefit, provide a level of cash value growth in the contract (at least at stated minimum levels), and pay the benefit in the event of death. The insurance company takes on both the **mortality risk** and the **investment risk** in the contract.

If more than the expected number of people die (determined actuarially), the company may be able to raise the mortality charges in the contract, but never in excess of the guaranteed rates in the contract. If the insurer does a poor job investing its funds, it still has to pay the contractual minimum interest. The owner can see the worst case scenario when he buys the contract.

In a traditional (non-variable) contract, the insurance company has to invest its funds in a relatively conservative manner. The company walks the fine line between maximizing returns and minimizing the long-term risk to the company and its policy holders. The contract owner implicitly accepts the company's investment philosophy when buying a permanent policy.

The consumer can assume the investment risk in a permanent policy by purchasing a **variable life contract**. Variable contracts can be fixed premium or universal (flexible premium) contracts. The owner chooses from a number of mutual fund strategies for the investment element of the contract. The owner can pick among the spectrum of funds from aggressive through conservative, even choosing a guaranteed fixed rate account. Owners can match their investment philosophy, or **risk profile**, with their investment objectives to create a contract unique to them. If your client selects a very conservative investment mix, you should probably consider recommending a traditional fixed product to best match their risk tolerance.

If the underlying investment performs well, the contract values will reflect that and the contract may perform substantially bit better than a traditional contract. The only cost to the owner is an investment fee that is contractually disclosed. However, if the underlying investments don't perform well, the **investment risk** is borne entirely by the owner. Just as the upside (potential for gain) goes to the owner, the downside risk does as well.

Many people tend to look at variable products in low interest rate environments, wherein traditional products show a level or decreasing interest rate or dividends. When interest rates go back up, many people look to traditional contracts for a combination of reasonable returns plus guarantees. Every client is different, and every need for insurance has a different flavor.

SINGLE LIFE VERSUS. JOINT LIFE PRODUCTS. Though the preceding discussion focused on product types for individual insureds, each product mentioned can be structured and priced for joint mortality situations. Some examples:

FIRST-TO-DIE. Like a lot of new product innovation in life insurance, **first-to-die** coverage is really just a refreshed, repackaged version of an old concept. It is a policy that covers two or more individuals and pays off on the death of the first insured. The concept comes in many product types, including universal life, variable life, excess interest whole life, and term. This is a lower cost alternative to buying multiple policies, although it does provide only one death benefit, and fits many needs where a death benefit is necessary only at the first death. Examples include dual wage earner families, buy-sell arrangements in business, or charitable giving situations involving life insurance, among others.

SECOND-TO-DIE OR SURVIVORSHIP. This policy provides a death benefit when the **second** insured dies, but no death benefit is paid when the first of the insured dies. In some policies, the premium is modified or suspended at the first death and some contracts show a large increase in cash values at the first death. This coverage is

very popular in estate planning situations. In many cases, people can defer estate tax payments at the death of the first spouse, with all taxes due and payable at the death of the second spouse. This policy provides the right amount of insurance at the right time. Again, it comes in all the popular policy types, and the selection of the right type of policy is critical. Once a need has been established for estate protection coverage, it is a permanent need. Most people's estates will continue to grow until their death; the estate will not be dissipated, so the need will continue to be there. The broker must understand precisely how permanent this need is---guarantees may take precedence over low cost.

For example, you may see the use of term protection as a "blend" in second-to-die policies to lower the cost of the contract. Part of the death benefit is permanent insurance, while another piece is term coverage. These policies are common among older people, and the cost may be a very important factor. This coverage can also be used in business settings for buy-sell coverage, or for dual income households that can survive the loss of one wage earner, but not both. Refer to the chapter on *Illustrations* for a full discussion.

INSURANCE PRODUCTS AS THEY ARE UNDERWRITTEN

GUARANTEED ISSUE. This coverage, usually for low face amounts on an individual basis, under $50,000, is provided to anyone who applies. There are no health or medical questions asked. Rather, the questions deal with who will be insured, who will own the policy, who will pay the premium, and who is the beneficiary. Guaranteed issue plans are very expensive coverages since the companies have to assume that most applicants will not be standard risks. This policy may have a graded death benefit and benefits are limited. In most cases, this sort of coverage features either a return of premium plus interest on that amount, or a percentage of the face amount for the first several years, with the full benefit is paid thereafter. If the death is from accidental causes, the full benefit may be paid even in the first few years. To get as much coverage as possible for a person with an uninsurable or marginal health history, a broker might have the client buy guaranteed issue coverage from several carriers. This provides, in total, the amount of coverage needed. Such coverage is sometimes available through sources like credit card companies or other lenders.

SIMPLIFIED ISSUE. This is essentially the same as Guaranteed Issue coverage, but the insurer retains the right to reject some applicants based on answers to a few, albeit limited, medical questions. The questions typically deal with working on a full-time basis, being diagnosed with or treated for certain diseases (AIDS, AIDS-Related Complex, cancer, heart problems), or engaging in hazardous sports or activities. Since some of the worst risks can be sifted out, rates are lower for this coverage than for guaranteed issue products, but still higher than for an underwritten one. There still may be a graded death benefit as an added protection for the insurer.

POLICY RIDERS

To allow a policy owner to customize an insurance contract, "riders" may be applied for and added to the base policy. By adding extra policy provisions such as those listed below, a broker can produce a policy that really meets the needs and concerns of his client.

WAIVER OF PREMIUM: One of the most popular riders, this provides that the insured will pay no premium on the policy after a certain period of disability. It's crucial that the broker understands how the company defines "disability" and explains this clearly to the insured. Also, the broker must clearly understands and describe the portion of the premium to be waived if disability occurs.

Waiver on term insurance is fairly straightforward: if the insured is disabled, the policy will stay inforce. On universal life, the premiums here are almost totally flexible. In most cases, the company will waive the monthly cost of insurance and expenses only. This way, the account values will continue to grow at current interest, but the company will not pay in any excess funds, even if the owner was doing so prior to disability. Some universal life contracts allow the policy owner to determine the exact amount to be waived including excess funds. In such cases, the premium will reflect, of course, the anticipated benefit. Likewise, on excess interest whole life plans, if the insured becomes disabled, some companies may only waive those premiums required to keep the policy inforce. So, if the premium had "vanished" on a policy and the insured later became disabled, no premium would be waived. If the premium "reappears" in the future and the insured is still disabled, the premium will be waived at that point. Don't assume anything on a waiver rider: make sure people know exactly what will happen if disability occurs.

ACCIDENTAL DEATH: Most people are familiar with the idea of accidental death benefits. This rider provides additional coverage amounts if death results from bodily injury caused by an accident. The death benefit is doubled if death occurs when the insured is a passenger on a common carrier (airplane, train, and the like).

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D): Similar to accidental death, AD&D covers not only accidental death as described above, but also pays for the loss, or loss of use of, certain body parts.

RETURN OF PREMIUM: Certain term contracts offer a return of premium rider. If the insured lives for a specified period and the contract is still inforce, the sum of the premiums paid will be returned. As you might expect, this can be a costly item to add to a policy.

ACCELERATED BENEFITS: A rider that has received a lot of attention recently is the Accelerated Benefits Rider. According to the Life Insurance Marketing and Research Association (LIMRA), this rider is attached to more than 18 million policies. An Accelerated Benefits Rider may promise to pay a percentage of the death benefit, up

to a stated dollar maximum, if a specified event takes place. For example, if the insured has less than six months to live or has been confined to an approved nursing facility for at least one year. Why is this benefit important? It gives the insured a chance to use the death benefit when it is needed the most---namely, before his death---and enables him to live out the rest of his life with some semblance of dignity and comfort. Note, however, that the death benefit will not be available later to benefit the stated beneficiaries, as was originally intended.

GUARANTEED INSURABILITY: The guaranteed insurability rider states that the insured can purchase additional coverage at specified dates or ages without further evidence of insurability.

COST OF LIVING (COLA): A Cost-of-Living Adjustment rider allows an increase to the face amount, usually every three years, based on an index (typically the Consumer Price Index). If the index increased since the last option date (or issue date) the policy owner can increase coverage on the next option date, without evidence of insurability.

EXCLUSION: An exclusion rider states specific illnesses, injuries or activities that are excluded from coverage. Remember, not all riders are available in all states, and are subject to state-by-state approval.

In addition to the riders above, which provide extra policy provisions on the primary insured(s), additional people can be covered for insurance through the use of riders. These types of **TERM RIDERS** may be written on:

SPOUSE: Some policies allow a spouse to be covered under a rider. The amount of coverage is typically not permitted to exceed the primary insured's death benefit.

CHILD: There are children riders where a small amount can be carried on each eligible child, usually up to age 21 or 25. This coverage is typically sold in "units" of $2,000 or $5,000, and total coverage on each child is typically limited to amounts in the range of $10,000 to $20,000.

OTHER INSUREDS: Some riders are available in which other insureds who are not family members, can be covered by rider. This is helpful in a business situation, for example, where three partners are looking for coverage on all of them for a buy-sell arrangement. In almost all cases these riders are term insurance and the cost is minimal. In fact, on universal life coverage, the additional cost is simply an increased cost of insurance charge taken from the policy values each month.

ANNUITIES

Though the focus of this chapter is on individual life insurance, a discussion of annuities is appropriate at this point. Not only is the annuity sale coincident to some life sales, it is important that you be at ease with the various payout options listed under immediate annuities and the features of single premium deferred annuities, since many cash benefits from life contracts end up in such vehicles.

Basic training in insurance tells us that products are supposed to protect against three things: dying too quickly, becoming disabled, or living too long. Annuities can help "protect" against living too long. Annuities are vehicles for accumulating cash on a tax-favored basis. They can help accumulate the cash required during retirement and provide a method of distributing those funds.

There are three kinds of annuities we will consider. **Single premium deferred annuities (SPDAs)** are contracts into which a single deposit is made. The money grows at competitive interest rates on a tax-deferred basis (that is, the interest is not taxed as it is earned or credited, but is taxed later when the money comes out of the contract). The money can be accessed in several ways, but often the policies are used as a longer-term depository for funds.

The second type of an annuity is a **Single Premium Immediate Annuity (SPIA)**. An SPIA is **annuitization**, which is a systematic liquidation of principal and interest over a specified period of time. Often the payments are made for the life of a stated individual. In such an example, the company looks at the accumulated funds, considers how long the annuitant can be expected to live and the interest earnings that can be expected over that time, and promises to deliver a certain amount each month, year or other specified period. If the annuitant lives longer than the company expected, he or she still gets that money. If the annuitant dies after one year, for example, the balance of the money stays with the insurer, unless one of the refund features described below has been selected. Payments can be made in a variety of other ways, including over a specified number of years or for the lives of two individuals. The method chosen will have an impact on the payment amount.

There are many **payment options** available under immediate annuities. These include:

LIFE ONLY---Payments continue for the rest of your life. This provides the highest payment, but there is no refund feature if you die too soon.

LIFE AND CERTAIN---Payments will continue for life, but never less than a stated number of years selected by you. The period typically selected is ten years.

LIFE WITH INSTALLMENT REFUND---Payments will continue for the rest of your life, but if you die before the principal amount has been paid, the balance of the principal will be paid in installments to your beneficiary.

LIFE WITH CASH REFUND---As described above, but the balance of the principal is paid in a lump sum to the beneficiary.

CERTAIN ONLY---Payments are made for a specified period of time, not for a measuring life.

JOINT AND SURVIVOR---This is used with two lives, often a husband and wife, and is also a popular form of pension payout. Payments are made for the annuitant's lifetime, with either the same or a reduced benefit continuing to the survivor. For example, a joint and 100 percent benefit or joint and 50 percent benefit is common. The percentage refers to the portion of the original benefit the surviving spouse would receive. A certain period may be requested, too.

The key in selecting any of these options is deciding how much income you need today versus the need to keep a stream of income going for the survivor. The choices made will have a major impact on the amount of the annuity payout.

In an **immediate annuity**, payments must commence one year from or within one year of the purchase date of the contract. Immediate annuities are often purchased by people who receive a large sum of money at retirement (perhaps from a qualified plan), who get a check for the sale of a residence, who have received a death benefit, have an SPDA they wish to slowly and routinely receive income from, or just want to use savings to guarantee a level of future income. A person's health is relevant when an immediate annuity is being purchased. Since life expectancy will be shorter if the person has certain health problems, the life benefit calculated on such a person will be higher than for a perfectly healthy one. Some companies specialize in handling impaired risk annuities.

The third type of annuity is a **flexible premium deferred annuity (FPDA)**. "Flexs" are contracts into which a series of payments can be made. If the annuity is going to be used as a long-term savings vehicle like an IRA, for example, there will be payments made every year. Again, the contract earns competitive current interest and has an underlying guarantee. Be aware that each new deposit to the contract might have its own set of surrender charges tied to it. There are flex's available, however, with no re-setting of surrender charges for new deposits. The actual annuity factors to be used when money is distributed are determined at the time of annuitization, as described above.

Deferred annuities can be either **fixed** or **variable**. A fixed contract has a stated underlying contractual guarantee of a minimum interest rate, and a current rate determined by the issuing company. So, there is a limit on the growth potential of the contract. A **variable annuity** is a registered product (see the earlier discussion on SEC products). The actual cash accumulation depends on the performance of the underlying investments. While these variable annuities can provide a hedge against inflation through some very impressive growth, they offer no guarantee on the principal amount.

Long Term Care Insurance

Long term car insurance (LTCI) has existed on some level for over 25 years with companies such as CNA and American Express pioneering some of the first long-term care policies. Much more attention and awareness was given to LTCI starting in the late 1980s and early 1990s, but the real surge in the market began when Congress passed the Health Insurance Portability and Accountability Act (HIPAA) of 1996 that created federal guidelines for Long-term care insurance. The policies that comply with these federal guidelines outlined in HIPAA are referred to as Tax-Qualified (TQ) Long-term care insurance policies. Policies which do NOT comply with the HIPAA guidelines are called NON Tax-Qualified (NTQ) LTCI policies.

Since HIPAA was passed, more and more insurance companies have decided to enter the LTCI Market, due in no small part to the fact that the general public has expressed an ongoing interest in long term care coverage. There is a growing need in the industry for insurance agents, agencies, and their staff to be aware of LTCI, and a basic overview of the terminology and mechanics of long-term care insurance is included in this manual.

Long-term care is extended care given to a person who is unable to care for himself and is typically provided either by an individual in the home or in some sort of a facility, such as a nursing home or assisted living facility. Many people still think that other forms of insurance such as private health insurance or Medicare will cover them in the event that they need extended long-term care, but normally this is not the case. Most of the time, health insurance and Medicare only pay for **SKILLED CARE**. Skilled care has nothing to do with how sick a person is but, rather, is based on whether he is progressively getting better. Once a person ceases to improve and his condition becomes chronic, the care he needs becomes classified as **NON-SKILLED CARE** and health insurance and Medicare will not typically pay the expenses incurred.

Long-term care insurance pays many of the expenses incurred for long-term care. HIPAA established federal guidelines for a Tax-qualified (TQ) policy. A tax-qualified policy itself must be guaranteed renewable and cannot provide cash refunds. In this case, refunds may only be used to reduce future premiums or increase benefits. However, a tax-qualified policy may not pay or reimburse you for care or services covered by Medicare. Certain guidelines called “benefit triggers” are contained within LTCI policies to indicate when they will begin paying the expenses incurred for Long-term care. The benefit triggers on a LTCI policy are dependent on whether it is a Tax-qualified or a Non Tax-Qualified (NTQ) policy. The federal guidelines for a Tax-qualified policy as defined by HIPAA established include a listing of the standard benefit triggers:

- A licensed doctor, nurse, or social worker has to certify that they expect a patient to be unable to perform at least two out of the six activities of daily living for a period of no less than 90 days or;
- A patient must be diagnosed with a cognitive impairment such as Alzheimer’s.

Only one of these triggers must be met for the "clock" to start. The Activities of Daily Living (ADLs) were not standardized by HIPAA, but the typical Activities of Daily Living used by most insurance companies today include eating, bathing, dressing, transferring, toileting, and continence.

The benefit triggers for a Non Tax-qualified policy are typically very similar to the Tax-Qualified policy, but often include an additional third benefit trigger called Medical Necessity. **Medical Necessity** simply means that a health care provider has indicated the patient needs care from a long term care provider for some length of time, but often it is shorter than the 90 days anticipated for a Tax-qualified policy. This lack of a time requirement on the medical necessity benefit trigger provides more latitude in a non Tax-qualified policy, and sometimes a person can "trigger" the benefits more quickly.

Two other differences between a TQ and NTQ policy are:

- **Tax deductibility** privileges—With a TQ policy, HIPAA provided some tax deduction incentives for people who qualify. Premiums paid by C-Corporations are 100 percent tax deductible with no tax consequences to the policy holders. However, an NTQ policy is not eligible for tax deductions.
- **Tax Consequences upon receipt** of the benefits—With a TQ policy, the benefits received will be tax free as long as the money received does not exceed the amount of charges incurred, or does not exceed the per diem amount allowed per year according to the tax code. Benefits paid out under an NTQ long term care Policy could be considered taxable income at a later date. Currently the IRS is not taxing these benefits, but the HIPPA regulation does not grant immunity from taxation.

Long-term care insurance policies tend to vary from company to company in small ways, though HIPAA established federal guidelines for these policies. Even TQ policies vary tremendously in what benefits are included in the policy.

There are 5 Basic Policy Components in every Long-term care insurance policy:

- **Daily Benefit**—The maximum benefit amount the policy will pay for facility care or home and community based care in a single day. This can range from as low as $20 to as high as $350. The increments are usually $10.
- **Elimination Period**—This is essentially your deductible. It represents the number of days in which no payment of benefits will be made for eligible charges incurred. Typically you can choose from 0, 30, 60, 90, 100 days and sometimes longer. The elimination period will normally begin with the first day of care.
- **Benefit Period**—The period of time your policy will pay for benefits once you go on claim. This period usually ranges from two, three, four or five years to lifetime. The benefit period is not a specified time period, but refers to

a "pool of money." For example, $100 maximum daily benefit used for 730 days, or a two year benefit period, is equal to $73,000. Benefits are exhausted when the pool of money is depleted. It is not based on a time period and the time does not have to be consecutive.

- **Home Health Care**—This is care provided by a licensed or unskilled person in the home. Many policies include this benefit, and some allow you to choose a percentage of the Daily Benefit that will pay for this care. The choices available are typically 50 percent, 75 percent and 100 percent. Of course, some policies can be purchased without the home health care option.
- **Cost of Living Adjustment**—This is inflation protection intended to help a policy keep up with the rising costs associated with long-term care so that it is still as valuable when it is needed as it is was when it was purchased. The typical choices are none, five percent simple, five percent compounded, or a CPI offer.

Ultimately, the most important part of LTCI is how it pays the benefits to a policy holder once he goes on claim. There are two basic methods that policies can use to pay out the benefits: Indemnity or Reimbursement.

The **indemnity method** means the policy will pay out the full daily benefit to the policy holder regardless of the expenses incurred. Most companies calculate this as a daily indemnity, meaning a person has to receive some sort of care that day in order to receive payment for that day. A few companies have a monthly indemnity, in which a person is paid in entirety for the month regardless of how many days he received care.

The **reimbursement method** means the company will reimburse the policy holder for the expenses incurred. Some companies still calculate the maximum reimbursable amount based on a daily maximum; however, many companies have gone to at least a weekly maximum, particularly for home health care expenses. In this case, the company takes the daily benefit amount on the policy and multiplies it by seven (for each day of the week), thus giving the policy holder a pool of money that can be used as needed through the week. The company will reimburse all of the expenses incurred throughout the week as long as it does not exceed this weekly maximum. The monthly maximum reimbursement works almost identically, but the monthly pool of money is calculated by multiplying the daily benefit by the number of days in the month rather than just the week.

Once a policy holder hits a benefit trigger, any elimination period on the policy must be satisfied before the company will start paying out benefits. Most companies require the elimination period to be met by **ACTUAL DAYS OF CARE** rather than according to the days on a calendar. Typically a company will start counting the days toward a policy holder's elimination period on the first day that care begins. Then, they will only count the days for the elimination period in which the person received some sort of care. For example, if a person is receiving home health care 3 days per week and he has a LTCI policy with a 90 day Actual Day elimination period, then it will

take him 30 weeks before the company will start paying benefits on this policy (3 days of care per week x 30 weeks = 90 actual days of care.)

Some companies are more lenient in the calculation method used for days that count toward the elimination period. Typically with these more lenient methods, a company will count all 7 days of the week toward the elimination period as long as a person receives a least 1 day of care during that week.

Following are general definitions of some other basic words or concepts that are important when discussing long-term care insurance.

- Waiver of premium—When the company allows the policy holder to stop paying premiums but continues to provide coverage
  - It is common for an insurance company to a least include a waiver of premium benefit on an LTCI policy if the policy holder is receiving home health care. Most companies offer joint waiver of premium even if only one spouse is receiving benefits.
  - It is important to review specific policies to see how the waiver of premium benefit works. Some policies will start the waiver when BENEFITS start; some policies will require some sort of "waiting period" (ex. 90 days) to be completed after care begins; some have a certain number of days of CARE the policy holder has to receive and then waiver begins. The mechanics of Waiver of Premium varies widely among the different insurance companies.
- Restoration of Benefits---A "reset" feature for the benefit period. If a policy holder goes on claim for a period of time and then goes off claim for at least 180 consecutive days, then the benefit period is "reset" or restored to its original amount. Sometimes this is included as part of the base LTCI policy and other times it is a rider that requires an additional premium.
- Respite Care---The company will pay for a certain number of days each year for the policy holder's primary informal caregiver to hire someone else to take care of the policy holder while he goes on vacation or takes time to rest.
- Bed Reservation---The company will pay for a certain number of days each year in which they will "hold" or reserve the policy holder's bed in a facility while the policy holder goes into the hospital. Some companies will allow the bed reservation benefit to be used under any circumstance, not just a hospital visit.
- Professional Services---Covers care from licensed health care practitioners such as a registered nurse; physical, occupational, respiratory or speech therapists; licensed social worker; and a licensed physician.
- Homemaker Services---A policy benefit that provides assistance with activities necessary to manage and maintain a household when the policy holder is no longer capable of managing those activities. Typically this person must be licensed through a home health agency, but some companies do allow this person to be an independent.
- Caregiver Training---Training given to the informal caregiver on how to take

care of policy holder.

- Alternate Plan of Care---A policy provision that pays expenses the policy holder incurs for care, treatment, and services not otherwise covered by the policy as long as it is mutually agreed upon by all involved parties. It is a "gray area" of a policy that plans for the future care that may be developed and beneficial for the policy holder but is not specifically outlined as a policy benefit.
- Hospice---Most policies cover hospice, which is care for terminally ill people, designed to keep them as comfortable as possible and provide respite care to family members.
- Third Party Notification---The policy holder designates someone else to get a copy of a lapse notice in case the policy holder doesn't pay the premium. This protects against policies lapsing because policy holders develop a mental or physical problem that makes them unable to pay the premium.
- Impairment Reinstatement---If the policy lapsed due to cognitive or physical impairment, the insurance company will reinstate the policy with appropriate premium payment within the specific time period, such as five, six, or nine months.
- Care Coordinator---This benefit pays a third party to manage your care (the caregiver) and report regularly to your family. This can be an independent care coordinator or you can use the ones affiliated with the insurance company. Some companies offer incentives to use their care coordinators.
- Return of Premium Rider---Upon the death of the policy holder, the company will pay to the named beneficiary the net amount of all the premiums paid in for the policy minus any benefits paid out. Some companies will pay back to the beneficiary all of the premiums paid in regardless of the benefits paid out.
- Survivorship Rider---Allows the policy to be "paid up" when the spouse dies if the policy has been inforce for at least 7-10 years. Some companies include this benefit as part of the base policy, while others offer it as a rider for additional premium. It is important to take note of the wording in the specific policy regarding this benefit because it can vary widely.
- Shared Benefit Rider---Allows a couple to share their benefit period in some way. Only a few companies have this benefit available, and they work in different ways. The common theme is the availability of a pool of money that can be shared between a husband and wife, or two people residing in the same residence, excluding parent-child relationships.
- Worldwide Coverage---Most policies will not pay outside the United States, but a few will pay worldwide, especially if you live in the U.S at least six months of the year. Some policies will pay for care in the U.S. and Canada.

When it comes down to actually selling LTCI to a prospect, there are a few important steps you should take to help it go smoothly for you:

- Pre-qualify your prospect to establish suitability
  - Do they use any medications
  - Do they or have they had any medical conditions?
  - Have they used tobacco in the last 5 years?
  - What is their height/weight?
  - What is their date of birth?
  - Have they applied for LTCI and been declined?
  - If they have been declined for LTCI coverage, when and why?
- Make sure you have the correct forms
  - A Shoppers Guide for LTCI is a required booklet that must be given to an applicant when you take a LTCI application. Some states offer their own version of a Shoppers Guide.
  - Some states require personal suitability worksheets to be fully completed and signed by both the applicant and the agent.
  - Some states require supplemental forms such as an Acknowledgment of Non-Duplication. This is required in Texas.
  - A replacement form is usually required if the client is replacing coverage.
- Utilize visuals when possible
  - A flip chart can be useful in helping a client understand his risk of needing Long-term care.
  - Spreadsheets illustrate how a cost of living adjustment benefit works in a policy over time.
  - Short summaries of the policy benefits can be helpful in explaining the differences between policies.

Education is key to understanding and, ultimately to selling, long-term care insurance. The more familiar you are with the basic verbiage and policy structures, the more easily you will be able to explain it to a client. The cost of coverage is "pennies on the dollar" compared to self-insuring the full cost of a patient's long-term care need. As such, long-term care insurance is a crucial part of a person's financial planning and retirement strategy

IV. THE INSURANCE APPLICATION PROCESS

A large piece of the Brokerage Desk Reference book is devoted to **applications**. Why are they so important? Why is there so much information required on an application? Why are they rarely filled out completely by the broker? Why do they take so long to process and approve? This chapter will provide the answers to those, and many more, questions.

WHAT IS A CONTRACT?

Before discussing **contracts**, we must first understand that a contract is a promise or set of promises, the performance of which is enforceable by law. A contract is enforceable through a process of offer and acceptance. Here is a simplistic example is:

> I offer to sell you a car for $10. If the car is known to both of us, and if you accept (a mere "OK" will do), we have a contract. If you offer me the $10, I have to give you the car. If I bring the car to you and hand you the keys and the title, you owe me $10.

In the real world, however, there are usually negotiations that take place before a contract is written. During such negotiations, each side makes certain statements on which the other side can rely. If the statements are not true, the contract may be voidable, if, indeed, a contract was formed at all

A life insurance contract is certainly a complicated item. It is a contract between the policy owner (often the insured) and an insurance company. It may involve substantial amounts of money, both premium payments and death benefits, and may be in effect for a very long time. No one buys insurance on a whim. The contract is a very serious and important item to all the parties.

The insured makes certain statements about his condition, both physical and financial. The insurance company evaluates the risk presented to it based on these statements as well as from information from other sources. The insurer may make an offer in the form of a contract, which may be at a different rate or type of policy than applied for. Until the offer is made and accepted, there is no contract. The owner may be able to form a contract by paying the first premium. Sometimes the application is viewed by the courts as an invitation to the insurer to make an offer. The insurer still has to review the application, assess the risk, and decide how to proceed. When the policy is issued, delivered, and the first premium is paid to and received by the company or an agent of the company, a contract is in place.

The application is attached to, and becomes a part of, the policy. It initiates the process that finalizes when money is made available to families and businesses that

need it. A complete and accurate application can speed up the whole underwriting and issue process. It can help avoid future litigation or delays in paying claims.

THE APPLICATION

An insurance application contains the specifics on which the underwriter bases his judgment to offer coverage or not, and, as such, it is important that the application be completed fully, accurately, and truthfully. The correct forms for the state the contract will be issued in and from the insurance company involved, must be completed by a broker who is currently licensed to do business in that state. Each state and company has a different definition of when an agent/broker is licensed to write business with that company.

Most contracts have a two-year **incontestable clause**. This means that after the policy has been inforce for two years from the issue date, the validity of the contract cannot be challenged unless fraud can be proved. The period of time during which **suicide claims** may be denied varies under state law; some states have one year clauses instead of two years.

The incontestability provision flies in the face of traditional contract law, wherein fraud invalidates a contract. After the two-year period has passed, the company cannot invalidate the contract and must meet the contractual promises of benefits to be paid. For a contract to be deemed unenforceable or invalid, the carrier must prove there was **material misrepresentation.**

When discussing non-enforcement of an insurance contract due to misrepresentation on the application or during the underwriting process, it is necessary that you understand what constitutes a material misrepresentation. A fact is material if, had a party known that fact, he or she would not have entered into the contract.

For example, if, at the time of application, the proposed insured said he or she lived at 123 Elm Street from 1989 to 1992, but really lived there from December of 1988 until 1992, this error may not be enough to invalidate the contract. If, however, a misrepresentation of fact would have changed the underwriter's offer of coverage, the claim might be contested.

A classic example of this involves the proposed insured who smokes but says he or she does not. A material misrepresentation of fact like this could result in **rescission** of the contract ab initio (from the beginning). The person would be deemed to not have had coverage, and would get a refund of premiums paid, plus interest, in some cases. That would be a far cry from the anticipated death benefit or surrender value. This lie would have to be discovered during the **contestable period** for the company to dispute the claim under traditional contract law. Several companies today treat an intentional misstatement of smoker status to obtain a lower rate as fraud against the company, and have attempted to rescind beyond the two year period.

INSURANCE AND MINORS. How are **minors** treated in the life insurance process? Under traditional contract law, minors can enter only into voidable contracts until age 21. That age has been lowered by statute to age 18 in most jurisdictions. In many places a minor can attain the capacity to contract merely by getting married. Traditionally, insurers have been very reluctant to enter into contracts with minors. Why? Under general contract law, the insurer must perform as specified in the contract, while the minor is able to void the contract at any time. So, the contracting process would be very one-sided in favor of the minor.

Juvenile insurance coverage is usually acceptable to insurers. The contract is made with an adult as policy owner and the minor as insured. Underwriting minors is a special area and is discussed more fully under "Financial Underwriting." Can minors be named as beneficiaries? In most jurisdictions they are not viewed as competent to receive the proceeds, so a guardian has to be appointed to receive them. Since this could be a costly and time-consuming process, it may be better to name a trust or trustee to handle the funds. Financial advisors should consult state statutes to determine the most appropriate method.

There are two kinds of requests for coverage you may run across working in the brokerage life environment: **trials (informal inquiries)** and **formal applications**. Let's consider each in detail.

INFORMAL INQUIRIES

Brokerage insurance companies often build their reputation on **substandard, or impaired risk, underwriting**. Companies that specialize in **impaired risk underwriting** can sometimes offer coverage to a person who, because of a medical condition, avocation, or financial situation, is highly rated or declined by a broker's primary carrier. The broker comes to your agency for help with these tough cases. Your response is important not only for that case, but for future business and referrals from that broker.

Instead of filling out a formal application for Company A and waiting to see what offer, if any, the company will make (and maybe then going to Company B, then Company C looking for the best offer), a brokerage agency will **"shop"** the case on an informal basis to one or more of its impaired risk carriers. The agency provides information to the underwriting departments of several carriers to determine what each company's offer would be if this case did come in as a formal application.

PHONE QUOTE

An agency can call the underwriter at a company and talk through the case with him or her. The information relayed to the company is the information provided by the broker. (See the chapter on "Impaired Risk Underwriting" for questions you should be asking the broker about impaired risk cases). A lot of agencies have a person or persons on staff with some underwriting experience. Sometimes this is the agency principal, but some agencies have hired underwriters from home offices to work in

the agency. The agency person describes the case to the underwriter, who offers a tentative quote (substandard rating) based on the information submitted. The agency repeats this process with a few companies, and has a range of tentative quotes on the case. The agency and broker can then decide which company is the best one for this case, and have a formal application completed for that one company.

Some companies will not make an informal quote without a signed authorization from the applicant. In such cases, a mailed or faxed copy of the informal inquiry's authorization can allow these companies to make a quote.

FAX, MAIL OR EMAIL-BASED QUOTES

The next method of making an informal inquiry is to fax, mail or email a limited amount of relevant information to a number of companies and ask them to make a tentative quote. The material sent for review usually consists of some general information on the potential applicant, along with relevant **Attending Physician Statement (APS)** material and medical test results. An APS is a complete record of an individual's medical history with a specific doctor. It should include all doctor's notes and test results covering the period of time the individual was under the care of that doctor.

THE INFORMAL INQUIRY FORM

The third way of getting a trial quote is to use an **inquiry form**. This form can be sent to several companies at the same time. The advantage of this form over the other methods is that when the **"Authorization to Release Information"** is signed by the potential insured, the insurer can obtain more information and therefore make a more "informed" tentative quote. If you use an inquiry form, that form must be approved by the law department of each carrier you intend to work with in this fashion.

A PERSPECTIVE

A tentative quote is only as good as the information given to the company. If the information on the formal application is different from that given during the trial process, the tentative quote will not hold. Also, note what makes a quote the "best" one. A quote is a combination of the rating itself, the products available, the company itself, the performance of the products, and the compensation available. So the best quote isn't always the one closest to standard; you need to run illustrations to measure performance. Only after these factors are examined can you decide what the best quote is. Quotes are always subject to current underwriting requirements.

THE FORMAL APPLICATION

One of the agency's most important jobs is to ensure that the application is filled out completely and accurately. This will enable the insurance company to process the application quicker, the insured to get coverage faster, and commissions to be paid on a timely basis.

The following suggestions and guidelines are a composite of the application process at several companies. If you are unsure about how to answer a question or complete a section, call or E-mail the New Business department of the company with which you are working. The people there would much rather answer your phone call or message than have to send the application back to you.

FILLING OUT THE APPLICATION. The application is part of a legal contract. All applications must be completed in ink and every alteration, erasure, correction, or addition must be initialed by the applicant. If an error is made, draw a line through the mistake, place corrected information near it, and have the applicant initial the correction. Do not use "ditto," dashes or expressions such as "see company records." Also, carriers prefer initialed "mark-throughs" instead of "white-outs." Most carriers will not even accept an application with "white-out" on it.

If it is your role to submit applications to the insurer for consideration, you must review the application to see if it is completed correctly and thoroughly. Make sure the client is eligible by age for the plan of insurance; minimum and maximum ages for each plan will be shown on rate cards or product descriptions furnished by the company. Verify if the company being applied to calculates age by the **"age last"** or **"age nearest"** method for that plan. In a similar vein, check to see if the correct amounts of coverage and premiums are indicated for each plan of insurance. Finally, verify the correct application for the state in which the sale is being made. Company reactions to an incorrect application range from sending the application back so a correct one can be completed (without the underwriting process starting), to beginning the underwriting process while requesting a correct application, to the home office filling out a new (correct) application for the broker to have signed as a delivery requirement. In any event, the underwriting process is interrupted or even delayed; this could have been avoided if the correct application had been used. Each company should provide a list of the appropriate forms for a given state.

THE **"PART ONE"**

Proposed Insured---The full name must be provided; if middle initial is used, that should be indicated. This information has to be furnished for each proposed insured.

Mailing Address---Addresses must be stated accurately. Street address, city or town, zip code, and any post office box must be included. It should be indicated if mail is to go to Residence or Business.

Occupation—The complete occupation of the proposed insured, name and address of the employer and the length of employment must be stated.

The Applicant (Owner)---If the applicant is someone other than the insured, the full name, mailing address, city/town, zip code and any post office box (if used) must be provided. The owner's social security number or tax ID number and relationship to the insured must also be indicated. If the owner/applicant is other than the insured, the application must be signed in the correct place to include the capacity in which the owner signs.

Policy and Additional Benefits—The plan of insurance for each applicant as well as the proposed face amount must be provided.

Premium Frequency/Mode---The premium frequency should be indicated in this section along with the amount of any premium submitted with the application. Each product brochure provides the modal factors to be applied. Be especially careful on universal life to ensure the client is paying enough premium to reach the desired goal. There really aren't modal factors for universal life, so the premium has to be increased if it is not paid annually. An illustration showing how the client wants the policy issued should be included with all universal life cases.

Benefits/Riders---Special restrictions may apply when adding riders to policies, so be sure to check the rate cards for details. In the case of a Child Rider, if the child is age 15 or older, the insured child must sign the application as well as the parents. Waiver of Premium riders are not available at age 56 or older.

The Beneficiary—Full names, dates of birth, and relationships for all beneficiaries must be included in the application. If the applicant is unable to suggest a specific person to receive the proceeds, the estate of the insured may be an appropriate choice. It is often advisable to name a contingent beneficiary who will collect the proceeds should the first-named beneficiary predecease the insured. Refer to the earlier discussion of minors as beneficiaries for additional assistance.

Existing Insurance---A complete inquiry about the applicant's inforce insurance is necessary to properly assess risk for the company. The application should indicate whether the coverage is for business or personal purposes. It should also be of value to the agent in determining the applicant's current life insurance program as well as whether any other coverage is to be replaced by this new coverage. Remember that certain states require that **disclosure forms** (a final warning to the insured that the old coverage will no longer be in place, and that the owner should consider whether he or she wants to replace it by listing comparative policy values and policy provisions) are required whenever a **replacement** is involved. Often these forms must be submitted with the application.

Premium Deposit---If a check will accompany the application, this section needs to be completed.

Special Activities---Each question must be answered fully. Any "Yes" response could require a questionnaire of some sort to be filled out. Depending on their responses, the applicant may be asked to complete an **aviation questionnaire**, for example, or perhaps one for **hazardous activities** or another **foreign travel**. There could be details required on military duty, smoking history, or motor vehicle incidents.

Remarks and Special Requests. This is an area where further details can be provided to "Yes" answers.

Home Office Additions and Corrections. This section is for home office use only.

THE **"PART TWO"**
Again, accuracy, neatness and full disclosure are critical to making a favorable impression on the underwriter:

- All information must be fully completed on each proposed insured. Name, sex, date of birth, place of birth, height and weight, and social security number must be shown.

- Names, addresses and phone numbers of all personal physician(s) must be shown. In addition to other requested information, the date of the last consultation and the reason for the visit should also be given.

- The questions that begin with "Has any person proposed for insurance ever been treated for or had any known indication of ..." must be completed in full. The broker must ask each question in its entirety and record the answer in the presence of the proposed insured. A great deal of responsibility rests upon the broker to see that proper, full and complete answers are secured. Any inaccuracies, omissions or incomplete answers will cause delay in consideration of the application by the company.

- The family history question is a "must" for underwriting. It presents to the underwriter a complete history for a better picture of true health.

The Authorization to Obtain and Disclose Information and the MIB---The application must be properly signed. If the applicant and spouse are BOTH to be insured, they BOTH must sign in the space provided. The date and location of the signature must be indicated. The signature(s) must be witnessed by another party, most frequently the agent. Alterations are not allowed on the authorization form.

Since the MIB generates many questions from brokers and their clients, it is important that you understand the purposes, limitations and scope of MIB. Alterations are not allowed on the authorization form.

MIB is a non-profit organization of insurance companies, and is based in Massachusetts. It provides data (codes, but not detailed descriptions) about the health history of applicants if that person has already applied for coverage with

another carrier. If a person applies for coverage with Company A, that company will report (in a general way) any significant information it develops during the underwriting process. There will be a code reported, for example, if the applicant has diabetes, or a heart condition, or a respiratory problem. This information will allow the next underwriter to obtain information based upon another insurer's health review and subsequently request certain tests, Attending Physician Statements and the like to determine if these conditions still exist and thus measure their impact on insurability. The underwriter will also be able to obtain knowledge on pre-existing conditions the client may have neglected to disclose. Conditions most commonly reported include height and weight, blood pressure, EKG readings, and X-rays if, and only if, these facts are commonly considered significant to health or longevity. There are also codes which will alert an underwriter to an adverse driving record, aviation activity, or participation in hazardous sports.

In addition to providing general codes relative to medical situations and adverse activities, MIB also provides information to an underwriter through its **"Insurance Activity Index (IAI)."** The purpose of this index is to alert insurance companies to applicants who might be over insuring by attempting to acquire life, health and/or disability policies from multiple companies. In addition, an underwriter will identify cases that are being "shopped" to multiple companies without their knowledge.

The general rule is that an insurance carrier cannot make an underwriting decision based on MIB information. This information can only supplement the data given on the inquiry or application and developed through normal underwriting requirements. There are two exceptions to this rule. MIB information can be used if the carrier states:

- It is clear that the MIB information relates to the same person being considered for the coverage and;
- The carrier obtained from the reporting company the documents supporting the reported codes, or was advised by the reporting company that the coded medical information was verified by a medical source or the applicant.

Overall, MIB information can certainly point the way an underwriter should go in the accumulation of facts upon which an underwriting decision **will** be made.

The applicant protected in the process by signing a release on the inquiry or application authorizing the insurer to request the information. All the material is confidential. The applicant can write to the MIB and request the information on file to determine if there are any errors. In the unlikely event that errors are found (fewer than one percent of applicants request a correction), the applicant can get the data corrected. The address of the MIB information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734; infoline@mib.com, 866-692-6901.

Many people believe that only when a formal application is submitted does a carrier report codes to MIB. That is not true. Even if an informal inquiry is submitted, the

carrier is required to code the case if an MIB authorization has been signed. Information remains in the MIB file for seven years.

The MIB process helps the insurance company get a complete and accurate picture of the applicant's health and past application history during the underwriting process. If the insurer can assess risk accurately, it can help people get more reasonable rates for their insurance.

The Premium Deposit Receipt and Conditional Coverage—Brokers and agency personnel should fully understand the conditions on this receipt to represent it accurately to insurance applicants. A **Conditional Receipt** should ALWAYS be given when any money, full or partial mode, is received. The amount collected should be sent in full to the company along with the application. If no money is received, the Conditional Receipt MUST be attached to the application when returned to the home office so there is nothing to imply liability on the part of the company.

Conditional coverage is temporary coverage (subject to the conditions outlined in the Conditional Receipt) given in exchange for the first modal premium. Coverage continues until either approval of the application or the expiration of the time limit stated in the Conditional Receipt. This provides the proposed insured with some coverage during the underwriting process. In most cases the temporary coverage begins when all medical requirements have been completed (e.g., exam, blood and urine) and ends if the company notifies the proposed insured that there is no offer of coverage and any monies received will be returned to the proposed policy owner.

Conditional coverage can be offered when:

- A new application is received with money.
- A policy is delivered and money is collected, but additional delivery requirements are outstanding.
- Anytime during the application process (with some companies).
- A policy has been approved and issued, but not yet delivered (again, with some companies).

Conditional coverage can be declined if the:

- Face amount applied for (and already inforce with some companies) exceeds certain limits.
- Company determines there is a medical condition they do not choose to cover.
- Application processing time exceeds the time limit the company allows for this coverage.
- Proposed insured's age exceeds company's limits.

Each company has different provisions for conditional coverage and when money can be accepted. Be very familiar with the procedures and limits of the various companies used by your Agency.

Some companies offer **"unconditional coverage"** which remains in effect during the underwriting period, perhaps up to 90 days. Where offered, this special binding is available only with a special form in addition to the formal application and payment for the temporary coverage.

Notice of Information Practices---This Disclosure Notice must ALWAYS be given to the applicant. Basically, this notice states that the insurer will be collecting data on the proposed insured, from a variety of sources, before any policy is issued.

Agent's Report---This section must be completed fully by the broker, who should be certain to clearly print his name in the space provided, and sign where indicated. Some of this information may be duplicated on a "Personal Statement" which might be required if the requested face amount is high enough. If commissions are to be split or assigned, make sure this section is filled out completely and clearly. The Brokerage General Agency also needs to complete the required questions for commission purposes.

In conclusion, it is extremely important that an application be reviewed for completeness prior to submission to the company. Since the application will become part of the contract, and it might be the basis for possible "contesting" of claims in the future, incomplete applications should be returned to the broker for completion.

UNDERWRITING: THE PROCESS

Your job is not over even after you get a completed application to the home office.

When the application arrives at the home office, the New Business department reviews it over carefully. They look for several things:

- Is this the correct application for that specific product in that state?
- Are all signatures completed?
- Have all questions been answered fully?
- Were changes initialed by applicant?
- Have the appropriate questionnaires been attached?
- Are the necessary state disclosure forms completed and attached?
- Has the licensing process begun, if required by state?
- Is an illustration attached for universal life sales?
- Was a summary sheet for underwriter review?

Assuming everything is in its place, a file is set up to hold the papers already sent in, and all the information that will follow. The company's underwriting requirements guide will tell you what information the underwriter will need to evaluate the risk presented. These requirements will vary based on the age of the proposed insured as well as the face amount of coverage requested.

ORDERING REQUIREMENTS---Depending on your Agency's practices, or upon the request of the Broker, **requirements** are ordered. Many insurance companies have lists of approved services who can arrange for medical requirements to be completed on the correct, approved company forms. If you are to order the requirements, the broker will provide the phone number and best time for his client to be contacted. No matter who is ordering the medical requirements, the broker, your Agency or the home office, it is important that the insurance companies who are to review the results be clearly identified. For example, each carrier may have specific blood or urine tests and markers required, and will not consider the risk unless the needed results are forwarded to them. Depending upon company rules, either they or the Brokerage General Agency will request an inspection report, if required.

Many brokerage agencies will order an **Attending Physician Statement (APS)** directly, and follow-up with the doctor to get the report in as short a time frame as possible. There is usually a charge for this from the physician and payment is generally required in advance. In most cases the Agency will be reimbursed for the pre-payment of an APS for formal application submissions. Reports can take several weeks or more to produce (or reproduce, since many merely make copies of their records), and one of the most important functions of a General Agency is to obtain an APS in a timely fashion through professional and persistent follow-up. All APS follow-up should be documented in the case file. Once the underwriter gets detailed information, he or she can make a more informed evaluation of the risk. Most companies have a medical director to assist the underwriters if there is any question about the APS, if there is an ECG to be read, or if something else more "medical" shows up. This resource is particularly valuable in some close calls; the doctor may be able to find some offsetting "good news" to facilitate offering a better quote.

When the application gets submitted, the New Business area runs the MIB report or, if requested, a **motor vehicle report** on the applicant (describing vehicular problems that took place in the state from which the report was requested: speeding, driving under the influence, accidents, operating a motor vehicle with a suspended license, etc.). The report might show something in the applicant's past that was not fully disclosed or described on the application. Sometimes the underwriter sees something on the application or the MIB about which he or she would like more information. Based on the MIB information the underwriter may request an additional APS or a special medical test. An APS can be ordered either by the Agency, by the home office, or through a service (like Equifax, PMS, EMSI, etc.) that would contact the doctor's office or hospital and request certain information. APSs ordered late in the underwriting process can create significant delays; every effort should be made to request relevant information as soon as possible.

SPECIAL FORMS

Certain requirements mean that special forms need to be completed. An example of this is an **HIV Consent Form**. This is used to obtain a proposed insured's permission to test blood samples for HIV/AIDS. It also allows the proposed insured to designate where the results should be sent in the event of a positive result (usually the proposed insured's primary care physician). This form can be completed either by the agent when the application is completed, or by the Paramedic when the blood is drawn. Not all states require this form, but every state that does require it has a unique form. The form has to be valid in the state where the blood is actually drawn and not the state in which the application is taken. Each company will have its own set of forms and a listing of where they are required.

Disclosure or replacement forms---Mentioned previously, these are strictly enforced state requirements. Regulations dealing with when, and on what forms, replacement disclosure forms must be submitted vary from state to state. Some states require that replacement forms accompany the application to the company and be dated the same date as the application, while others permit a number of days in which they can follow. The data provided on the inforce and proposed insurance plans are subject to state audit. Fines are assessed for forms not being completed when required or for not being completed correctly. Know the regulations and requirements for the states in which you do business.

HIPPA FORMS

Supplemental information forms may be requested to cover specific situations such as a proposed insured that has diabetes, asthma, cancer history, coronary history, or participates in unusual or high-risk professions or avocations, such as scuba diving, racing, skydiving, flying private planes, mining, etc. There are also **personal and business financial questionnaires** which may be required or voluntarily done to assist in underwriting the case. **Questionnaires for foreign nationals** or for those who **travel** outside the United States are frequently required.

UNDERWRITING UPDATES

It's not a completely perfect world in which we do business. If it were, all the required medical information would land on the underwriter's desk at the same time; the underwriter could look at the case all at once and make a decision. It doesn't happen that way in real life. In real life the APS can take a long time to get to the company, the tests might not have been done when they were supposed to be, and interesting new medical facts may have popped up during the underwriting process (requiring more tests and APSs to be ordered). So, given this slightly flawed process in which we participate, how do the agency and the company know what's happening to a case at a specific time?

Communication between the Brokerage Agency's case manager and the appropriate underwriter and New Business person is vital. Either through email, fax, phone or

websites, it is crucial that the outstanding requirements on a case be clearly identified and every effort made to obtain them in a timely fashion.

The most efficient method of staying on top of a case is through the use of **electronic download**. NAILBA has established a standard pending case record for electronic communication purposes. Each night, after a new case is set up at the home office with information received from the agency and outstanding requirements updated, the home office's computer prepares a pending case record and sends it to the agency's computer. Every night thereafter, when that case's status changes in the home office, an updated case record is transmitted. This allows the agency case manager working that case to know the first thing each morning the exact status of the case at the home office as of the close of business the previous day. Download information can include application clarifications required, medical requirements ordered and received, status of lab tests, APSs, licensing, quotes, offers, proposals and much more. No phone calls or letters are required, just a personal computer. Both sides of the sale know what's happening on a case at all times.

Here again, NAILBA has been a big help in the process. **NAILBA** has developed a set of standardized **"codes" for pending requirements** on cases. If the underwriter is looking for a coronary artery disease questionnaire on a case, the code "CADQ" will appear as a Remark for that case. "SNAPP" will show that a signature is needed on the application. Most brokerage companies will use these NAILBA codes to make it easier and more uniform for you to keep track of cases in the agency. There should be copies of all the codes available in the agency. You'll learn the most common ones just through repeated use; you may have to look up some of the lesser-used ones.

OTHER ISSUES DURING UNDERWRITING

BACKDATING TO "SAVE AGE" ---You may get a request to have a policy **backdated**. This means issuing a policy prior to the date of the application. In general, this is done to give the insured the benefit of a premium based on a lower age. The insured pays for some coverage he or she did not use (after all, he or she is still alive), but there is a lower premium for the life of the policy. The insurance company will typically allow a six month backdating limit. Check with Underwriting and New Business to be sure on a particular case. The key to this decision is if the company uses an age nearest or age last method for calculating age. Some states have backdating limitations.

ALTERNATE POLICIES---Sometimes an agency or broker will request that an **alternate policy** be issued. Typically, this is another policy with a different face amount. This is often done when the proposed insured is not sure how much coverage is needed or affordable; both policies can be placed on the table, and an informed decision can be made. The policy that is not placed is returned to the company and never placed in effect.

Another important reason alternates are requested is in connection with **impaired risks**. Once an offer has been made and accepted by a proposed insured with a health history, a broker will often come back to the Brokerage Agency and the insurance company and ask, "What is the maximum amount of coverage you will issue on my client beyond the amount applied for with the medical and financial requirements in your hands?" This will then determine the amount of the alternate policy. The agent will encourage the client to accept this alternate policy because the rate at which the policy is issued can always be reduced if health improves, but can never be increased even if health deteriorates. The client has everything to gain and nothing to lose.

LICENSING---Is the broker currently **licensed** with the appropriate company in the state where the case was sold? If not, he or she needs to be. It is not usually a long process, but we all try to avoid any delays in getting commissions paid, and commissions cannot be paid to a non-licensed agent. Usually the process of licensing and appointing a broker with a company takes place concurrently with the underwriting of the case, though some companies wait until the case is ready to be placed before they incur the cost of licensing the agent. This is just a simple reflection of placement ratios: not all issued cases get placed by the broker, but the insurance departments do keep every fee sent to them. Some states have laws which require agents to be appointed by the company before presenting a proposal or taking an application. Still others require that an agent be appointed before a commission is paid. It is important to know the licensing regulations which apply in each state in which your agency transacts business.

There are different rules with respect to being licensed to sell **variable life** and **variable annuities**. These products are regulated by the **Securities and Exchange Commission (SEC**) as securities. The investment gains and losses in these contracts are borne solely by the policy owner. What are the licensing requirements to sell variable life policies or variable annuities?

1. The person must be licensed in that state to sell life insurance.

2. The person must be an **NASD (National Association of Security Dealers)** Registered Representative. To become a Registered Representative with a broker/dealer (an organization licensed to sell securities), the person must pass the **NASD Series 6 or 7 exams** on general securities. Some states require agents to pass the **NASD Series 63 exam, especially if they are doing business in a non-resident state.**

3. Some states require an agent to obtain one or more of the following in addition to a standard life license: a **Variable Contracts license**, a **Variable Annuity license**, a **Variable Life license**.

"SELLING" THE CASE

Following are some general thoughts about selling the case to the insurance company. A General Agency (GA) and broker can get business issued faster and maximize sales and commissions by preparing a case correctly for the underwriter. The other side of the coin is that the underwriter must do all he or she can do to help the GA and broker. The goal is the same for the GA, the broker and the underwriter: to write business.

No one likes to say "no" when a "yes" is possible. There are times, however, when an underwriter cannot accept a risk, or must come back with a **table rating** or **flat extra** to preserve the company's product and financial integrity. If you can improve an offer on a case by presenting it fully and correctly, it is certainly your job to do so. There are many times that a full explanation can help an underwriter in his decision-making. For example, if you know that financial justification of a business case will be difficult due to recent unusual happenings within the business, you should request a letter of explanation and justification from the business' financial officer. A company brochure or even newspaper articles about the company may be helpful to the underwriter in understanding the financial justification for a case. Or, if you know a proposed insured always has high readings as part of his blood work-up, and that a physician-specialist has said these readings are of no concern to the client, you should get an APS letter from that specialist early in the case to explain the situation to the underwriter.

To help place the "unusual" case, you must package the case carefully and thoughtfully. You might want to include a letter from the proposed insured describing self-care, lifestyle (exercise and diet) or even a photograph. On the other hand, it is up to you to know the underwriting standards of your carriers, and to try to match the risk to the carrier correctly. Sending an impaired risk case to a preferred risk carrier does not make good use of your time or the carrier's.

What if you're not sure if a proposed insured is appropriate for the company and plan requested? Is the company competitive on this type of impairment? Are there any special requirements for this type of risk (a questionnaire or a special test)? If you have specific questions about a case, call or E-mail your underwriter. All underwriters want to help assure that cases are submitted correctly - it avoids wasted effort on everyone's part.

Sometimes things happen while an underwriter is looking at a case. What if the case came in first as a trial inquiry, then a formal app was submitted because the company gave the best tentative quote? If the requirements end up showing the same things as outlined on the trial papers, the formal offer will generally be the same. If some of the facts are different, the formal offer could be better or worse than the tentative quote. Some negotiations would have to take place if the offer were worse: the client might be expecting one premium, for example, and get a much different one. If the final offer is more expensive than the original quote, the broker and the client are going to be upset and expect explanations. You should temper tentative quotes with warnings that the quote may change as additional evidence is received.

Another way successful agencies work with their underwriters is by notifying the underwriters about what they need to sell the case. If you know that the proposed insured will only accept a standard rating, then put that fact up front on the summary sheet or in the discussion. If you know you need a premium below "X" dollars, let the underwriter know so he or she can do everything possible to meet that goal.

Often the impaired risk company is not the first one to see a case. If your case is being shopped and you already have an offer for table two and need to meet or beat that, let the underwriter know. The underwriter can more quickly see if he or she can compete with the prior quote (on a premium or rating basis) and thus help the case's momentum toward issue.

Another way to prepare the underwriter is to provide any information you have about how well the proposed insured takes care of him or herself. Some cases do fall between ratings and are judgment calls on the part of the underwriter. If the person is on a particular diet, give details. If they exercise regularly, provide details of how, when, and for how long. If, after reviewing all the medical evidence, the underwriter is still caught between two ratings, lifestyle factors may be enough to earn the better rating.

You may have heard the industry story about the agent who always sent in a Polaroid snapshot of the proposed insured. This agent knew that every week an underwriter looks at hundreds of case files - cold facts, reports and words - but the underwriter never sees who he or she is underwriting. A picture paints a thousand words. By adding a photograph of all his clients, the agent made his cases stand out in the pile. He added a bit of warmth and reality to what can be a cold, scientific process. We don't know if his placement rate was any better than anyone else's; we do know his cases were noticed.

"MOVING" A CASE. Here's another example of the "imperfect world" syndrome. Sometimes a case is withdrawn from one company during the underwriting process and the intent is to send the case to another insurer. It could be that the second company is better on underwriting a certain impairment, or it has a better product for a certain need. Will the first company release the medical information it has developed on the case to the new insurer? Remember that the first company has been paying for the information along the way. An insurer is not required to release such information even if the proposed insured requests them to do so. The home office may charge an appropriate fee for transferring such information although there usually is no such charge. Some companies are very slow in releasing this information, others will not do it at all, and others mail the information in a timely fashion. Caution is necessary to ensure reasonable expectations on the part of the broker and the client. If the proposed insured wants to authorize the release of medical information to another insurance company or to a personal physician, a written, signed request must be sent to the insurance company currently holding the records. If the proposed insured is requesting release of records to a personal physician because a policy was issued other than as applied for (a rating, for

example), the proposed insured should request that justification of the offer made be given and forwarded along with the medical records.

DELIVERING THE POLICY

There are many steps that have to be completed to get a policy placed. The last step is the **delivery of the policy** and the collection of the premium. Sometimes the premium will have been paid with the application. Other times, the owner will want to pay by having the premium deducted from a checking account. Each company will have its own processes for setting up this collection method. Most companies require at least two months' premium before the policy will be put inforce. After two months the premium amount will be automatically deducted from the account. Since commissions are paid on premiums collected, agents will typically encourage a policy owner to pay on an annual (or at least semi-annual) basis. We are probably not far from having premiums charged to credit cards or debit cards.

If the contract is ready to be issued, but some provision will be different from that applied for (e.g., the original rating, beneficiary, owner, face amount, plan, premium, rider or other provision), the Issue area will create an **amendment**. This is a formal document that, when signed, changes certain original provisions. An **endorsement** is a similar document that makes changes to an existing policy. The document (with original signatures) is part of and included in the contract. Often amendments are determined when a policy is issued and must be signed before the policy can become effective.

Delivery requirements (those items to be completed before a policy can be put inforce) may include:

- Amendments to be signed
- New Part I or Part II to be signed
- First modal premium
- Void check and check-o-matic form if needed
- Policy delivery receipt (some companies)
- Health statement
- Any other requirements identified by the company

The agent must ensure that the proposed insured has had no change in health since the application was signed. The agent then completes all case delivery requirements and sends them to the agency. The case manager checks all the items for completeness and accuracy and forwards everything to the home office.

FREE LOOKS. All states require that there be a **free-look provision** in the contract. This is a state-mandated contractual arrangement to give the policy owner a certain period of time (usually 10 or 20 days, depending on the state) to examine the policy and return it to the company if he or she is not satisfied with it for any reason whatever. The provision begins to run when the policy is delivered, so many companies are very careful about the delivery requirements, especially the receipt. These can be used as "evidence" of delivery later in any dispute.

NOT TAKENS. You may hear that a policy has gone **"NTO."** This means that it is not accepted by the applicant, or **"not taken out."** There are some common reasons given for a policy not being taken: the case was rated and the owner cannot afford it; the applicant's financial situation has changed; the applicant received a better offer; or, the coverage is no longer required or desired. A policy is considered NTO when it is returned by the applicant or broker during the free-look period, or when the delivery period for the policy has run out before all the outstanding requirements have been met. Either way, it ends up as no sale, and no commission will be paid to the broker or the agency. A lot of work by a lot of people went for naught. Some companies charge a fee when a case goes NTO; some agencies have a way of charging the brokers if they get "hit" for that money. If a broker establishes a pattern of not placing issued cases, you may have a very expensive broker with whom you are doing business!

V. FINANCIAL UNDERWRITING

In Chapter III, titled "Insurance Products and The Needs They Fulfill," a list of some of the reasons life insurance is purchased is given. Once a need for coverage is established, fact-finding will help to determine the insurance coverage amount required for this specific client. Life insurance has become relatively inexpensive; especially term life insurance; however the ability or willingness to pay the premium does justify the amount of insurance requested. A review of relevant financial data will take place during the underwriting process prior to policy issue. It is the role of the broker and, in turn, the Brokerage Agency, to present data and justification to the underwriter to support the requested face amount.

Why is the financial underwriting process so important? A life insurance policy is a legal document. The policy owner must have a valid **insurable interest** in the life of the insured at the time the contract is formed. The concept of insurable interest also differentiates life insurance from speculation or gambling. This is different from a property-casualty type contract (like fire insurance) where the insurable interest has to exist at the time of claim.

Insurable interest means that a person or entity will suffer a financial loss in the event of the insured's death; a financial loss would not have occurred in the event that the individual had lived. That risk of loss has to be shown to the company before a contract will be issued. Due to insurable interest requirements you cannot take out a large face amount of life insurance on a public celebrity and then cash in when the person dies, as you have no financial interest in the continued good health of this individual. The requirement of insurable interest is what differentiates a life insurance policy from a form of gambling. Requiring insurable interest helps to protect each of us from an untimely death which could be orchestrated by someone who has more to gain from our death than from our life.

An obvious example of insurable interest exists between married couples, as they each depend upon the others continued good health in order to earn a living and reach their joint financial objectives. A spouse may be listed as the policy owner & beneficiary, as they have an obvious financial interest in the life of the applicant in the event that the applicant lives or dies.

In general, a person always has an insurable interest in his own life. The amount that will be issued is an amount that can be justified by the facts presented to the company. Most states allow any person or entity to be named as beneficiary although a few states require the beneficiary to have an insurable interest as well. No one would want to name a person as beneficiary if that person had more interest in the insured being dead than alive.

In 1882 the United States Supreme Court gave its view of insurable interest:

> It is not easy to define with precision what will in all cases constitute an insurable interest, so as to take the contract out of the class of wager policies.

> It may be stated generally, however, to be such an interest arising from the relations of the party obtaining the insurance, either as creditor of or surety for the assured, or from ties of blood or marriage to him, as will justify a reasonable expectation of advantage or benefit from the continuance of his life. It is not necessary that the expectation of advantage or benefit should always be capable of pecuniary estimation, for a parent has an insurable interest in the life of his child, and a child in the life of his parent; a husband in the life of his wife, and a wife in the life of her husband. The natural affection in cases of this kind is considered as more powerful, as operating more efficaciously, to protect the life of the insured than any other consideration. But in all cases there must be a reasonable ground, founded upon the relations of the parties to each other, either pecuniary or of blood or affinity, to expect some benefit or advantage from the continuance of the life of the assured. Otherwise the contract is mere wager, by which the party taking the policy is directly interested in the early death of the assured. Such policies have a tendency to create a desire for the event. They are, therefore, independently of any statute on the subject, condemned as being against public policy. *Warnock v. Davis*, 104 U.S. 775 (1882).

Financial underwriting must demonstrate the existence of insurable interest in measurable (a financial sum) terms.

There are usually two categories of financial underwriting: **personal and business**.

PERSONAL NEEDS. There are several ways of expressing personal needs and arriving at an amount of coverage:

Income Replacement - this can be determined in several ways. The most frequently used method is multiplying the total earned income of the individual by an accepted factor. As a rule of thumb, underwriters use about 10 times income at the middle ages, higher at the younger ages, and lower at older ages. These figures tend to reflect the potential earning years of the individual. Remember, the 10 times figure is intended as a broad guideline; the actual figures used will vary based on the company, so you should always check with your underwriters. Another method is to start by determining the amount of annual income necessary for the surviving spouse. This annual figure can then be divided by the anticipated investment return (usually 4 percent to 6 percent) to determine the insurance amount needed.

Estate Settlement Costs - a popular use of life insurance is to provide liquidity for the payment of federal estate and state inheritance taxes and other administrative costs. Preservation of one's assets for future generations is important to many, particularly since shrinkage from taxes alone can reduce an estate by as much as 55-60 percent. Administrative costs can equal 5-10 percent of the total estate (toward the lower end as the estate gets larger). To obtain the amount of coverage needed to satisfy this need, the underwriter compares the liquidity needed to the available liquid assets and then values the "net" need. The planner may wish to include some reasonable inflation factor to be applied to the estate to arrive at the final figure. A universal life

second-to-die contract may offer an increasing death benefit option to help with inflation; a participating contract will offer paid-up additions to work in a similar fashion.

Coverage for Personal Loans - the underwriter will be looking for information like the amount of the loan, the name of the creditor (lender), terms of the loan, purpose of the loan, and whether the creditor is requiring the insurance as a condition of making the loan. The beneficiary wording on the application needs to include wording that the proceeds will be paid to the extent of the outstanding obligation, with the balance going to another named beneficiary. This is often referred to as a **collateral assignment**. A separate form (**"Collateral Assignment Form"**) needs to be completed for the insurer. In most cases the insurance company will not cover the full amount of the loan, and will not issue a policy if the loan does not extend for more than five years. An exception is a mortgage loan on a primary or secondary residence, which can be covered in its entirety.

Juvenile Coverage - usually these are small amounts of coverage, like a $10,000 rider on a parent's policy, unless there are extenuating circumstances (a substantial inheritance, for example). Some factors underwriters will review include: the amount of coverage on the parents, coverage amounts on siblings, the ownership and beneficiary designations, and the purpose for the coverage.

Charitable Giving - an underwriter may look at a person's or a couple's historical giving patterns and project that out to life expectancy to determine an appropriate insurance amount. The underwriter will also consider whether there is enough other coverage inforce to satisfy other needs of the client.

2008 Federal Tax Regulations allow for any person to give $12,000 to any other person ($24,000 if a husband and wife both give the gift) without incurring any gift tax obligation. This $12,000 or $24,000 amount is called the **annual gift tax exclusion.** People may buy an amount of insurance coverage based on what this dollar amount can purchase at their age, assuming the $12,000 gift will occur each year. The premium may be gifted to the policy owner or trustee, who in turn will pay the premium due. Some companies will still want justification for the face amount produced in this way. This is a routine planning device, and is one that will be understood by the underwriting area; share such facts in your cover letter.

Final Expense Insurance - there are policies offered for final expenses ("burial policies") by many insurers. These are for very small amounts of insurance and are usually issued with minimal underwriting.

BUSINESS NEEDS. Business needs can also be divided up into categories.

Buy-Sell - the underwriter may want to see a copy of the buy-sell document to determine how the price of the entity was determined. If it was reasonably done, an individual's insurance need will be determined by the ownership percentage multiplied by the value of the entity. Sometimes the value will be established at the

time of death (the fair market value); if so, there will need to be an estimate of the current value so some coverage needs can be fixed. As a general rule, underwriters will apply a factor of ten times to net profit for a mature business, and may consider large amounts of retained earnings as justification to increase the insurance need.

Key Person - underwriters will look at the age of the individuals and their responsibilities in the company. If they have unique skills, important relationships and contacts, or are responsible for bringing in a lot of sales to an organization, the entity may need to be protected against the loss.

Business Loan Coverage - many of the same factors that apply to personal loans also apply here. Business loans cannot be covered by insurance in their entirety and the life insured must be a principal of the company with duties or responsibilities related to incurring, sustaining or repaying the loan. A company's president and chief executive officer would be such a principal. In insuring a business loan, the business is usually the owner and beneficiary of the policy and frequently collateral assignments are used.

Deferred Compensation - these are plans where the entity promises to pay amounts in the future to key persons if the people continue to work to a certain age. Life insurance is a perfect vehicle to informally fund the agreement because of the immediate death benefit (if the person dies) and the growth of the values in a permanent plan (if the person lives). The underwriter will be concerned about the financial viability of the business entity, and will want to be sure that the face amount is not too high relative to the person's worth to the company.

What will follow are suggestions of how you can assist in the financial underwriting process by providing the required information early in the underwriting process. This will speed up the issue of cases and avoid "no's" from your underwriters.

WAYS A BROKER AND BROKERAGE AGENCY CAN ASSIST IN FINANCIAL UNDERWRITING

In any case where financial underwriting takes place, the underwriter is going to look at the whole case to "feel" if it makes sense. A lot of judgment and experience goes into these decisions; the agency can make a lot more of them go in the broker's favor by presenting the case in a professional way.

THE COVER LETTER

A key element in case presentation is **the cover letter** on the case. This will be the first exposure the underwriter has to the case and we all know what people say about first impressions. The broker and the agency can go a long way toward getting the underwriter to "buy into" a case with a good letter. The cover letter should be a summary of the important elements of the case. What are the essential elements of a good cover letter?

You should **summarize the application**. Show the client's name, and the face amount being requested. State clearly the plan of insurance being requested, and the premium amount. State the owner of the policy as well as the beneficiary, and show the relationship of each to the client.

Be candid and helpful. Explain fully any potential problems with the case. The problems may be medical ones, or they could be financial. Don't hide them; get them out in the open for consideration and discussion.

Talk about the **financial objective** of the coverage. Does it make sense? Why? What is the need? Who will lose because of a death, and how much? How did you arrive at that amount?

Talk about the broker's knowledge of the client. Is it a personal relationship or just professional? What is the depth of the relationship? Are there other advisors involved in the case? If so, who are they and what are their professional qualifications and what have they recommended?

SUPPLEMENTAL DOCUMENTATION

For **personal insurance** justification, be prepared to support the financial objective with **documentation**. Make the case as easy as possible for the underwriter to understand and, if necessary, sell to the reinsurers. Enclose copies of relevant personal and business financial statements. Include copies of employment contracts if they are important, or trust agreements if they are involved. Overall, show the thought process that was used to establish the need in the case and to arrive at the requested amount of coverage.

For business insurance justification, you should consider adding one or more of the following documents to the case file to help in the underwriting process: financial statements, tax returns and business agreements. The key financial records will be a balance sheet and an income statement. Audited statements are the best, since they are based on generally accepted accounting principles. It is very important to have the records from the most recent accounting period, and the prior two years' records are helpful to establish trends. Tax returns can aid to establish income amounts, but these are not usually required by the underwriter. Copies of any business agreements to be "funded" by the insurance (buy-sell, deferred compensation, loan agreement, etc.) will be helpful to the underwriter as well. The more supporting information you and the broker can provide, the more easily the underwriter can justify the amount applied for.

SPECIAL ISSUES

Though there are no (or few) "tried and true" absolutes in financial underwriting, there are some special issues which can be generalized. What follows are some guidelines which might be acceptable to your underwriter.

BANKRUPTCY/DIVORCE/UNEMPLOYMENT. There are a few special situations where it might seem tough to financially justify the need for a large amount of life insurance. Underwriters like to see **bankruptcy** claims discharged (settled by the courts) before the person applies for coverage. A person emerging from bankruptcy may have little or no net worth, but could be earning a substantial income. Underwriters will recognize that situation.

If the client is **divorced** and receiving alimony, this will show up on the personal statement, probably as "unearned income." Responsibility to pay child support and/or alimony should be disclosed during the inspection process.

In a similar fashion, a **non-employed** person who has inherited a lot of money (for example) would show that asset as part of his net worth on the personal statement. The personal statement is made part of and a supplement to the application; it is required by most companies for younger applicants with relatively high face amounts requested. If the person is older or the requested face is higher, an inspection report (done by a professional firm) is often an underwriting requirement.

VALUING A KEY PERSON. One piece of the puzzle you may want to include if the coverage is on a key person is a computation of the person's value (in a purely economic sense) to the company. A lot of companies will use a multiple of 5 to 10 times compensation to justify an amount of insurance on a key person. This compensation amount would include salary, bonus and ownership percentage of the corporation's net income. If you need to justify a slightly higher amount, provide the reasoning in the cover letter.

In a March, 1989 article in the Journal of American Society of CLU & ChFC, Brian S. Brown, CLU, ChFC wrote about "Large Case Underwriting: A Challenge for Producers." He discussed three key items that are very interesting in determining the value to a company of a key person.

- He pointed out that the compensation of a replacement executive may have to be significantly higher than that of the predecessor if the new person does not have an ownership stake; if that person's labor is not building equity in the organization, he or she will seek higher current compensation levels.
- In addition, there may be significant recruiter fees to identify the new person. Those fees range from 15 percent to 25 percent of the executive's first year compensation, and should be calculated as part of the executive's replacement cost.

- Finally, it will probably be 2 to 3 years before the new executive will be fully functioning in the position; there is a cost to the company in this transition period.

All these factors can be considered in "valuing" the key person for purposes of determining an appropriate insurance amount. One other factor that can be added is this: if a key person has been personally signing for loans for the corporation (collateralizing with personal assets), this fact could increase the replacement cost for the individual. The corporation would have to find another source of collateralization for these "extra" funds.

NUMERICAL GUIDELINES

Though every company establishes its own underwriting categories and parameters, and every underwriter makes his own decisions based on "facts and feel," listed below are some very general guidelines which may be of value to you. The majority of financial data, since it is confidential, will be disclosed during the formal inspection and go directly to the underwriter for consideration. However, justification of coverage is a conversation which often takes place during the underwriting process.

PERSONAL INSURANCE NEEDS. Personal insurance is basically income replacement and a means to facilitate estate preservation.

Income is defined as earned income plus any employer-paid bonuses reasonably expected to be earned through performance. Income does not include unearned income which would continue to the beneficiaries or estate following death. **Remember these multiples are only guidelines; each company will have different rules and procedures**.

Ages	Income Multiple
to 35	15X
36-45	10X
46-50	8X
51-55	6X
56-60	5X
61+	4X

In the case of **Juvenile Insurance**, all children in the family should be insured for equal amounts up to 50percent of the parent's coverage, or an amount equal to the annual income of the major breadwinner. If the grandparents or another party are gifting the premium, be sure that is explained fully in the cover letter. Typically, juvenile insurance is issued in amounts up to $250,000. Larger amounts are considered and issued when justification is provided.

Charitable Bequests---Often underwriters will ask if the proposed insured has made contributions to the named charity in the past. Typically, insurance will be issued for the amount the proposed insured would have given had he or she lived.

Estate Liquidity---When considering coverage for estate tax purposes, future appreciation should be taken into account. Some insurers will index an estate value by 7-9percent per year for up to 10 years in the future. They will do so when the makeup of the estate indicates future growth is likely. The insurance amount will be based on the tax liability on the indexed estate value. One company even predicts the future value of the estate taking into account the life expectancy of the younger insured. Any direction you and the broker can give to the underwriter to determine an appropriate value will be very helpful.

BUSINESS INSURANCE NEEDS

Loan Coverage:

- Minimum length of loan usually four or five years
- Non-collateralized usually insured up to no more than 70 to 80 percent
- Collateralized usually insured similarly, though sometimes less depending upon the liquidity of the collateral
- Copy of loan agreement is helpful and often required

Buy-Sell:

- All partners must be insured
- Need to know ownership percentage of each applicant
- Copy of the agreement will often be required

Keyperson:

- Generally five to 10 times the income of the key person, depending on type of business and the insured's duties

In closing, you should always remember there are no absolutes in insurance, and every case is a little different from the one before. The more precise the documentation and explanation provided to the underwriter, the better chance that the case will be successfully underwritten!

VI. IMPAIRED RISK UNDERWRITING

Independent brokerage as a distribution system developed from **impaired risk underwriting**. Decades ago, "shopping" a case to improve an underwriting result was an unknown activity. Most life producers were agents of major career life insurance companies, and a rated or declined case was a final decision.

Brokerage agencies developed as certain life insurers began to offer more aggressive underwriting than that offered by the career companies, creating a market for shopping rated and declined life applications. Expertise was required to properly build a complete file and present it as a shopped case, and brokerage agencies developed the necessary skills sets. Indeed, many of the earliest brokerage agencies were founded by former home office life underwriters to market their impaired risk expertise.

An impaired risk is a substandard risk or a risk presenting an impairment disqualifying it from a carrier's standard rates. Impairments can be mild, severe or uninsurable, and they can come singly or in combination with others. Mild obesity may be offered standard rates, for example, as a mild impairment. Obesity is often complicated, however, with hypertension, diabetes or coronary artery disease, presenting a risk with multiple impairments. Carriers in this market have varying tolerances for both single and multiple impairments.

Resident expertise in the impaired risk business should include a mastery of medical terms and understanding of the impairments and their implications, and the types of ratings an underwriter is likely to assess to the various impairments. Further, an understanding of medical testing is necessary. Finally, a brokerage agency proficient in the impaired risk business should be able to communicate with its home office underwriters and medical directors on an "underwriter-to-underwriter" basis.

There are multiple rate categories within the life insurance industry, including preferred best, preferred elite, preferred plus, preferred, elite, standard plus, accelerated standard, standard, and so forth. A "rated" case, then, does not include someone who was approved at standard rates as opposed to preferred rates. The standard classification is the baseline for where every client should fit amongst all carriers. **Anything better than standard should be considered a privilege**.

Ratings on life insurance are given in two ways: either with a table rating or with a flat extra. Generally these additional ratings are placed on top of the standard rates for the carrier to create a substandard risk. A few minor exceptions exist, and BGAs need to make sure they have the most current information from each carrier to see how these additional rates are actually applied.

Table ratings are the most common "rate-ups" in life insurance. Substandard tables represent multiples of standard mortality, and are expressed as percentages of Standard, generally in twenty five-percent increments. Table 2 (or Table B, depending on the company) shows 150 percent of Standard. Table 4 denotes 200

percent, and so forth. Note that these percentages are multiples of mortality derived from the incidence of death in a very large pool of lives. They are not multiples of risk. A Table 4 risk, for example, is not twice as likely to die as Table 2 risk.

Each table carries an extra premium. In term insurance, the extra premium usually relates to the base premium, so a Table 2 risk would actually pay 150 percent of the Standard premium. In permanent insurance, each table carries its own premium per age and gender.

Less common than table ratings are flat extras. A flat extra is an underwriter-assigned extra premium stated in dollars. Flat extras can be temporary or permanent and are expressed on a per-$1,000-of-life-insurance basis. Flat extras are used commonly for avocation risks and frequently in combination with table rating for some impairments. Private aviation, for example, often carries a rating of $3.50 flat extra per $1,000 of life insurance. Some cancer ratings combine tables and flats such as Table 4 plus $5.00 flat extra per $1,000 for five years.

This chapter identifies some questions you should ask about various impairments. The answers to these questions will help tell the underwriters what they need to know to give you a tentative quote **or best case scenario** on the case. If you use this section while you're working on an impaired risk case, the whole process should run smoother and more effectively and help you establish a **higher level of credibility** with both your carriers and your broker.

The underwriter will need to have specific concerns answered, regardless of the major impairment, including:

- What is the client's height and weight?
- Does the client use tobacco products, and if so, in what form?
- What does the client's family history look like?
- Are there any current medications being taken?

After that basic information is gathered, the underwriter is sure to want other questions answered. These are specific to the various impairments and are described in detail in the following pages. NAILBA has developed several products, including the **NAILBA Field Underwriting Guide** and the **NAILBA APS Summary Course** to provide every BGA with the majority of the information necessary to present any case to any underwriter and get at the very least a tentative medical decision.

SURPRISE "HITS"
NICOTINE, DRUGS, ALCOHOL, LAB RESULTS

What do you do when a proposed insured tests positive for one or more of the following: nicotine, drugs or alcohol? Or the proposed insured has excessively abnormal lab results? The answer will depend on whether the applicant admitted the use or history of these abnormalities, or if it was discovered through the inspection or medical testing done during the underwriting process. Companies will have different ways of handling each of these situations, so let's look at the most common reactions.

NICOTINE

The layperson would probably consider anyone who smokes a cigarette, a cigar or a pipe to be a smoker. This might also extend to anyone who uses tobacco in any form, such as smokeless tobacco products including, chew, dip or snuff. Most insurers would consider these people to be smokers, but some companies have finer gradings in their classifications. Some companies consider only cigarette smokers to be in their "Smoker" category, while others include any tobacco use that results in a 3.0 or greater nicotine finding in the urine specimen. So, a person could smoke a cigar or a pipe and still be called a nonsmoker at some companies. **It is very important that the brokerage general agency stay current on all carriers' stance on tobacco use through their published guidelines.**

We discussed earlier the risks associated with misrepresenting facts on the application, an action that could lead to a claim being contested. Stating that a proposed insured is a nonsmoker when, in fact, he smokes, would most likely be viewed as a "material misrepresentation."

Chances are good that the urine specimen on a smoker will come back with a positive nicotine reading. It will be up to the broker to provide further information on purportedly "nonsmoking" clients. If the client says he does not use nicotine and the reading was due to "passive smoking," then the underwriter will make a decision based on the lab results and company policy.

DRUGS

What if the urine tests show a positive result for drugs, such as cocaine? What can the client do then? Some companies will decline the case outright: this is a risk they are not willing to underwrite. Other companies may elect to postpone the case for consideration for two to five years. That means they will not even underwrite the case for that period of time, and then only if the person has not been using the drug for that time. Once the case may be underwritten, the broker should expect to see a table rating of four to eight tables. A case can be issued standard for a rehabilitated cocaine user after three to four years of abstinence, but probably will not be issued preferred.

What if the client insists that the results are incorrect, and that he or she never used cocaine? A test on hair follicles can be an easy, albeit expensive, way to settle the issue. This test not only shows what kinds of drugs were used, but also indicates the amount in question. Additionally, it can detect usage from up to 90 days prior, whereas the urine test is typically only effective up to three days prior, indicating very current use. If a finding is contested by the applicant, some companies will allow a **follicle test**, and almost all will consider the test at the client's expense. Be sure to ask the carrier that is underwriting the case prior to obtaining this test if it will benefit the client. Some carriers will not review any additional information in these cases and it is important to know that prior to having the test completed.

If the applicant admits to a history of drug problems, and the client has been clean and sober for at least 2 years, many insurers will look for ways to issue coverage for that person. They will want answers to the following kinds of questions:

- How many kinds of drugs?
- What kind (illicit or prescription)?
- Was alcohol involved?
- Is the applicant a smoker or nonsmoker?
- How long did the abuse last?
- Were there mitigating circumstances, such as back pain, marital difficulties, financial problems?
- Were there criminal activities involved?
- Was this a relapse, or have there been relapses since?
- Did the applicant participate in support groups or talk with family/friends?
- What current medications is the applicant using?
- Were there any medical consequences of the drug use, such as stroke or myocardial infarction?
- Has the applicant been arrested for any felonies or driving convictions?

The company is trying to write policies, too, but it needs to understand the effects of the drug use on the person as well as the potential for abstaining in the future.

ALCOHOL

The underwriter may see several signs of **alcohol abuse**. For example, the client may admit to it on the application and in an alcohol questionnaire. The underwriter will consider how long the client has abstained, the kind and amount of alcohol abused, examine the support mechanisms, consider relapses, and look for any ratable drug use. The results of the blood tests may reveal some abnormal elevations in liver function tests. **Underwriters have access to several alcohol "markers" (specific tests) that eliminate causes other than alcohol for the test results.** Once the underwriter has established that alcohol is a problem for the candidate, appropriate questions can be asked to determine the extent of the problem and the ultimate disposition of the application. For both drug and alcohol problems, a complete family history, including a discussion of any family problems in these areas, is very important.

ABNORMAL LABS

When reviewing the blood profile and urinalysis that are completed as normal age and amount requirements, the underwriter may find results that will preclude them from being able to make an offer for coverage at any rate. This includes abnormal liver functions, kidney functions, lipids, etc. In these cases the underwriter may ask for additional testing or may postpone the case for the proposed insured to go to his personal physician to get additional testing completed to determine the cause of the abnormality. Once the proposed insured has completed the additional testing and the cause for the abnormality has been discovered and treated and the laboratory results have returned to normal, the proposed insured is able to reapply for coverage and will be underwritten with the new information.

No book can cover all possible medical conditions, but we have tried to list the most common ones here, and help you work most effectively and quickly with the broker and the underwriter.

As much as various agencies may excel in different areas, **different insurance companies have their niches**. It is to your advantage to learn which of your carriers successfully underwrites in the impaired risk marketplace, and with which impairments each carrier is most comfortable.

VII. THE REINSURANCE MARKET

Reinsurance is the means by which insurance company transfers risk to another company. The reinsurer acts as a money lender of sorts and is a joint risk taker with the insurance company. Many refer to reinsurance as insurance between two insurance companies.

The primary company that issues the policy is called the "ceding" company and the company to which the risk is transferred, in part or entirely, is the reinsurer. The act of transferring the insurance from ceding company to the reinsurer is called a cession. If the reinsurer should transfer all or a portion of their risk to one or more companies, this action is called a retrocession.

The agreement between ceding companies and reinsurers are categorized into two types: automatic or facultative. Under an automatic agreement, the reinsurer is required to accept a specified amount of insurance for each piece of business determined by the insurance company's retention limit. A common calculation used to determine the limit at which the reinsurer will automatically cover is four times the retention limit of a primary insurance company.

The ceding company sets the retention limit by determining the amount of risk it can afford to keep for its own account. Each carrier will set its own retention limit and that limit may vary according to how new the insurance company is, how much surplus it has, the quality of the underwriting staff, and the percentage of the business that is impaired. Any amount above a company's retention limit will be sent to a reinsurer.

In a facultative agreement, the primary insurer may offer to the reinsurer specific case risks. The insurance company is not obligated to accept the risk. Each entity has the right to determine its own course of action for each individual risk. The primary company has to submit all papers to the reinsurers.

There are several types of reinsurance plans, the most common---the yearly renewable term plan. The primary insurance carrier purchases annual renewable term insurance from the reinsurer. These rates are very competitive due to the fact that the reinsurer does not have to pay for commission, medical fees or any additional fees connected to the policy. Costs are fixed in advance which makes this plan easier to administer than the coinsurance plan.

With the coinsurance plan, the reinsurer is not only responsible for the face amount but also for the pro rata share of the cash value and other surrender benefits. In essence, the reinsurer becomes the surrogate insurer while the primary company remains liable to the policy owner if the reinsurer becomes insolvent.

There is also a modified coinsurance plan. With this plan, the primary carrier pays the reinsurer a proportionate part of the gross premium much like the traditional coinsurance plan. However, at the end of each policy year, the reinsurer pays the

primary insurer any excess reserve noting that the reinsurer never holds more than the gross premium for one year. The advantage of using this plan over an annual renewable term plan is that usually there are less net costs of reinsurance in the beginning policy years.

After each agreement, the primary carrier completes a cession form that describes the risk, the schedule or premium, and the commission (if any). It also states the type of reinsurer plan, and how premiums are to be paid.

During the claims process, the reinsurer usually pays a lump sum to the primary insurer. If the policy is settled for less than the death benefit, the reinsurer will share in the savings. At the same time, if the primary insured contests a claim, the reinsurer will pay its share proportionately.

THE JUMBO CASE MARKET

Reinsurance is a critical element in the process of placing **jumbo (very large face amount) cases**. If the requested face amount is over the insurer's **automatic limit**, the insurer has to get reinsurance. On very large cases, the reinsurer will not keep the entire risk either. The reinsurer has to go to the next level of risk sharing, the "retrocessionaires" and tell them it will be looking for coverage. You will find that many insurers share the same reinsurers and, in turn, **retrocessionaires.** The insurer may be working on a $50 million face amount case: its reinsurers will be looking to push off some of that risk to their retrocessionaires. If the applicant has applied to three companies looking for the best premium offer, there could be a capacity problem in the reinsurance market. For example, no reinsurer would want part of that $150 million of coverage, but it might have participated in the $50 million.

Thus, a large case shopped to too many insurers may be lost since each insurer will obtain commitments during the underwriting process to hold **"capacity."** The first insurer that does this might tie up that reinsurer's available line and make any subsequent inquiries from other insurers receive a "not willing to participate" decision.

It is *very* important to answer the question on the application about existing coverage and any other coverage that has been applied for. If the reinsurers can be told the total amount of coverage desired (including this new policy), it will be easier to obtain the proper reinsurance. That will make it easier and quicker to get the policy issued and delivered.

In the jumbo market, a competitor may quickly call its intended carrier before underwriting even begins to tie up the market and thus control this case's work-up and underwriting. You can only be successful in the jumbo market if the broker and client do not flood the market with inquiries and applications. You must do all you can to control the case.

Glossary of terms:

- **Industry Jumbo**---Amounts applied, inforce, and to be replaced in all companies (all purposes)
- **Internal Jumbo**---Amount at which a company must send the case facultative if they need reinsurance support (varies by company)
- **Reinsurance—** 'Insurance for insurance companies'
- **Retrocessionaire**---'Insurance for reinsurance companies'
- **Retention**---The maximum amount of risk at a given age and underwriting classification a company will retain on any one life
- **Automatic binding**---Ability to cede the risk to the reinsurer without the reinsurer having to evaluate the case. Limited by inforce, applied, and rating classification.
- **Facultative cession**---Any case sent to a reinsurer to obtain an offer of coverage. Reasons for submission include medical, financial, aviation, avocation, occupation, capacity, excess of internal binding, Jumbo limits
- **First dollar quota share arrangement**---A method of proportional reinsurance in which a ceding company cedes a certain percentage of the entire risk to an assuming company or companies despite the presence of a retention limit—that is, the ceding company cedes coverage from the first dollar

VIII. PREMIUM PAYING ALTERNATIVES

The objective of this section on premium payment options is to provide you with an overview of the issues involved with paying premiums and of the common methods used to pay premiums.

As you become involved in more complicated cases, you may find that this resource does not provide the answers you need. In those instances, we recommend contacting an Advanced Sales Specialist at one of your life insurance companies.

The most important element in any sale involving life insurance is the identification of the potential loss. Once the broker helps the client recognize and understand this loss, protecting against the loss becomes a natural consequence and there is generally nothing better than life insurance for protecting against a loss.

When the Premium is Paid

Introduction

Life insurance is a contract with two parties. One party must make an offer to the second party. The second party must accept the offer to put the contract in full force. Acceptance of an offer must include some form of consideration, which is usually, but not always money. Sometimes the second party requests changes in the offer before accepting it. This is a counter-offer.

- Cash with the application---An applicant makes an offer to the life insurance company when he completes an application, fulfills the underwriting requirements, and submits consideration. This can be with a check for the full modal premium. Recent changes in the industry allow for payment of initial premium with a credit card or completing a bank draft authorization with an express request to the insurance company to draft the first premium. If no money is submitted, the applicant must make an offer to the life insurance company, and, in turn the life insurance company may accept the applicant's offer by issuing a policy as applied and putting the policy in full force and effect. The applicant must give special attention to ensure the conditions of the Conditional Receipt (CR) or the Temporary Insurance Agreement (TIA) are met. This will generally include:

    - Checking the application for complete answers and to be sure none of the answers invalidate the condition of the CR or TIA.
    - Calculating the modal premium to make sure that it is correct for the premium modal factor requested.
    - Making sure all underwriting requirements as listed on the CR or TIA arrive at the home office prior to the CR or TIA becoming valid.

- Paid on Delivery—Frequently, a policy is issued by the life insurance company with Delivery Requirements. The policy will not go into full force and effect until the completion to the satisfaction of the life insurance company of all Delivery Requirements.

  When the life insurance company issues a policy for an underwriting class higher than applied, for example Standard rather than Preferred, then the life insurance company has rejected the applicant's offer and made a counter-offer to the applicant. The applicant may accept it by completing the delivery requirements and paying the additional premium.

- How the Premium is Paid—There are typically four options for payment of a premium:
  1. Annual
  2. Semi-Annual
  3. Quarterly
  4. Monthly

  Each life insurance company has its own formula for calculating the correct modal premium. Frequently, life insurance companies allow a discount for electronic funds transfers (EFT). Verify your life insurance company's ability to use EFT.

- Prepayment Accounts—Life insurance companies frequently will accept advance premiums at a discount. Those that do will have a table or discount factor you can use to help your broker calculate the correct amount to pay. The life insurance company will treat the interest earned on the pool of money created by the advanced payment as income to the policy owner. For example:

Annual Premium	$1,000
Discount Factor	Five percent
Advanced Payment for 10 years	$7,721.73

  Policy owner pays $7,721.73 with the application or on delivery of the policy. The life insurance company deducts $1,000 to pay the first year's premium. The balance of $6,721.73 earns interest at five percent. Assuming the payment was made January 1, the policy owner would report $337.59 in interest on his/her tax return.

- Lump Sum Payments—Some insurance contracts allow the policy owner to pay a premium greater than the scheduled, annual amount directly in the insurance contract. Generally, universal life, variable universal life, and some whole life contracts allow this feature. The benefits to the policy owner include (1) reducing future premium requirements to carry the policy to

maturity and (2) avoiding interest income for the discounting effect of the advance premium.

- Sources of Premium—An important element in the sale is finding the appropriate source for paying the premium. Some might say that this is the most important part of the sale. Making sure that the applicant is confident of a reliable source of funds to pay the premiums will go a long way toward a successful sale. The source for the premium will depend upon a number of factors, including but not limited to: purpose of the insurance, employment status, financial situation, and age. When the potential loss extends for a long time, finding a steady, reliable source of money to pay the premiums becomes very important.

    - Policy owner's Personal Funds---Applicants with a substantial, steady income or significant savings accounts offer good sources for premium payments. In this instance, a savings account means any fund used for the accumulation of money. A common priority for using personal assets is as follows:
        - Personal, after-tax income
        - Non-qualified savings accounts
        - Qualified savings accounts

    - Savings accounts----Savings fall into two categories: qualified and non-qualified. Care must be taken to make sure that deducting premiums from savings accounts do not conflict or harm other objectives of the savings account. Non-qualified savings accounts have received contributions with after-tax dollars. The sum of these contributions will equal the basis in the account less any withdrawals. Some accounts may have surrender charges or other penalties for early withdrawal.

      Qualified savings accounts have received contributions with pre-tax dollars. All distributions are taxable to the plan participant. The participant may incur other charges and penalties for early withdrawal as well.

      When an insured uses personal funds and creates a trust to own the life insurance contract, the insured has made a gift to the trust. Consideration must be given to the gift qualifying for the annual exclusion from gift taxes and to the extent the insured's Unified Credit absorbs the gift.

      In all cases, make an effort to match the use of personal funds for personal life insurance needs. Watch ownership and beneficiary designations to achieve the proper client objective.

    - Business/Company Funds—The applicant may look to his/her place of employment as a source for premium. If the applicant is the owner of

the company, s/he may prefer to use the business as the source for premium payments over personal sources. Common uses of Business/Corporate funds are to pay premium for:

- Key Employee Insurance
- Section 162-Bonus Plans
- Group Carve-out Plans
- Non-qualified Deferred Compensation Plans
- Split Dollar Plans

Under current tax law, when the company benefits from the life insurance contract, the premium paid is not deductible to the company. This applies to key employee insurance, non-qualified deferred compensation plans and to split dollar plans.

In the case of Section 162 Bonus Plans, under current tax law, the company actually pays a bonus to the employee and the employee receives the bonus as additional compensation. The employee then uses the money to pay for a life insurance policy that has a personal objective for its purchase. The main concern with these plans is whether the bonus to the employee is reasonable. If it is not, then the payment to the employee is treated as a dividend. The dividend is not deductible by the company and is still taxable to the employee.

In the case of Group Carve-out Plans, under current tax law, selected employees of the company purchase life insurance in excess of the company's group plan. All the issues present in a Section 162 Bonus Plan apply to this if the company pays the premium

Split Dollar Plans are a way to mix the purpose of the insurance with the source of the funds. Split Dollar Plans offer a wide range of options for an employer to pay all or a part of an employee's life insurance premiums. Split Dollar may involve relationships other than employer-employee. There are two cautions with Split Dollar Plans. First, the IRS has published guidelines pending further review and potential changes that may impact both current and future plans. Second, Split Dollar Plans, generally, provide an attractive method for purchasing life insurance with someone else's money. However, unless the applicant has a well-defined and monitored exit strategy, Split Dollar Plans may create significant financial issues for the long-term participant of these plans.

Since 9/11, anti-money laundering rules have changed the modes of premium payments. Companies no longer accept money orders, cashiers checks, third party checks, or checks made payable to the agent or agency that is endorsed to the insurance company. Any premium payment has to be made with US funds drawn on a US bank that is directly controlled by the owner/insured or related payer.

IX. ILLUSTRATIONS: THE PAST, THE PRESENT, AND THE FUTURE

THE PAST

"The past" isn't that long ago. Beginning in the 1970s, the Federal Trade Commission (FTC) started to voice concerns about the relatively low rates of return in life insurance products. Consumers were just beginning to experience big-time inflation and, while other financial instruments were showing double digit returns, permanent protection from life insurance had rates of three percent or less. Life insurance had always had a savings element, but it had not kept up with other products.

The FTC made statements during this period that people wanted higher returns from their insurance. Around the same time, however, the National Association of Insurance Commissioners (NAIC) commissioned a study to find out what consumers really wanted during the insurance-buying process. The results of this study identified four major consumer concerns:

1. Competent agents.
2. Agents ready to recommend appropriate kinds and amounts of coverage.
3. Policy understandability.
4. Premium outlay (what they paid each year, not "net cost").[5]

In the late '70s, the NAIC moved to meet some of these concerns. Their solutions dealt mostly with advertising and presentation of figures. One attempt was the Life Insurance Disclosure Model Regulation. Another was entitled "An Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance." That's a fairly loaded title, and it showed that the public was wary of the industry as a whole. The NAIC was trying to guide companies toward clear and complete sales materials so that information would not be misleading to a person of average intelligence and education. Contract "readability" became the watchword of the day!

In response to people asking for some change, the industry gave them a revolution. Products were "unbundled" for the first time: that is, the elements of mortality, investment and loading were clearly separated and identifiable. In the past, permanent life insurance used to be something of a black box: you put some premiums in one side, a miracle took place, and you had some death benefits and policy values come out the other side. Unless you had an actuarial background, you didn't even make an attempt to understand what happened in that black box.

Prior to the "computer illustration age" of the 1980s, agents would carry rate books, or binders that showed premiums for a certain age and a certain amount of coverage, along with the corresponding guaranteed cash values for the end of years

[5] W. Stoltzmann,"Sanity in Policy Illustrations," Best's Review, 143. Oldwick, NJ: A.M. Best Co. Inc., June, 1988.

five, 10, 20, and at age 65. There were no personal computers, laptops or hand-held machines. Computers were the things that filled up the basements of Home Offices. They cranked numbers all day, but not to produce sales illustrations. Life was very different then, and it was easier to present a product. Innumerable product alternatives were not available, and the decisions were less complicated: term or whole life

Actuaries unveiled the black box, and gave us universal life and variable products. These are a lot like the old products, but in a clear plastic box: you can see what's happening inside. These products feature flexible premiums, expense charges, mortality costs, accumulation accounts and surrender values, death benefits that can go up and down, and interest rates which are guaranteed and current. Fortunately, this change was coincident with the acceptance of personal computers as a staple of business life. Now there was a way to present all the "what-if" scenarios: what if this much premium is paid in the following years, with interest rates doing the following, etc. Illustration software was designed to present these products in different settings: split dollar presentations, deferred compensation and the like. A simple decision to spend "X" dollars to buy "Y" coverage had now become a complex series of alternatives and options.

The illustration wars began. Incredible product flexibility presented opportunities to be "creative" about product design and illustrations. Clients began buying the illustrations, rather than the products behind them. Brokers were selling pieces of paper with number projections on them, rather than focusing on a client's intrinsic need for protection. In some cases, the key selling point became the gross interest rate on the policy, and other policy provisions and costs were not even discussed.

IN WHAT WAYS CAN AN ILLUSTRATION BE CONFUSING OR EVEN MANIPULATED?

MORTALITY COSTS---In some contracts, such as universal life or excess interest whole life for example, mortality costs in the contract can be charged on a current basis, and backed by a guaranteed (higher) figure. The company can assume a lower cost today when the contract is being sold, and still reserve the right to raise these costs in the future (if the mortality experience is not as good as assumed), once the policy is written. In par contracts, changes in mortality costs are reflected in dividend scale adjustments. When looking at policies, it is very important to attempt to note how much the mortality rates can be raised, and if they ever have been. Another assumption that can be made is improvements in future mortality. The logic goes like this: people are living longer today than when our parents were young. Science is moving a lot quicker today to cure a lot of diseases. So, in 20 more years, people will be living even longer and we won't have to charge as much for mortality. Therefore, the illustration will look even better. If the mortality charges are very aggressive or anticipate some future improvement, the company could have to increase costs later if the assumptions are not met. If the actual results are better than expected, will the company reduce the costs or keep the "extra money" as gain? Know the companies with which you do business, and know what the guarantees are!

INTEREST RATES---Another variable element in the process, interest rates add a lot of questions to the predictions. What if the current rate that is higher than the guaranteed rate? How long is the current rate guaranteed? Is there an outside (independent) index used by the company to trigger a change in the rate, or is this based on the investment returns of the company? Is the interest based on a new money rate or a portfolio rate? In a "new money" environment, each year's investments are separate, and crediting rates are based on the return for that limited block. Portfolio rates combine a number of years or products together and determines a crediting rate based on the average return for that block. The new money concept looks great in a rising interest environment; the portfolio strategy works better with declining rates, since older and higher figures tend to hold the overall return up.

Some illustrations credit additional "bonus" interest in the future for policies inforce at a specified time (and on all illustrations, all policies persist forever). Such bonus interest should not, however, be assumed to be credited on all inforce policies of a company. For example, if a policy is currently crediting 7.00 percent, there may be 0.25 percent more credited in the 15th year, and another 0.25 percent in the 20th year. Is this additional "bonus" interest contractually guaranteed, or is it an administrative practice of the company? Will future interest rates credited to those policies eligible to receive "bonus" be lowered to allow for the guaranteed bonus? As management teams change, so can these practices. Clients may not want to rely on something that can be illustrated but perhaps not delivered.

POLICY LOADINGS---Expense loads and surrender charges can also be illustrated on a current basis, with higher, guaranteed figures in the contract. If the company needs to raise these charges in the future, it can go right to the guarantees. The client may want to leave or surrender the contract, but there could be costs associated with that as well.

It may be in your best interests to have all illustrations run to endowment or some other chosen age. A particular illustration may be quite attractive for the first 20 or 25 years, and that's all that is shown. What the client may not see is the values being extinguished shortly after that and a large premium being necessary to keep the contract running.

COMMISSIONS---In addition it should also be noted that commissions can be manipulated through the use of term riders when combined with the base policy (since term is lower cost and carries a lower commission). Term costs continue to rise in the future on an annually increasing basis. Most illustrations assume that dividends or excess interest will be sufficient to pay these increasing costs, and perhaps even "vanish" the premium. If the dividends are less than projected or the excess interest credited is less, the owner may be left with a contract where he or she has to pay higher premiums for more years.

A SPECIAL NOTE---Two other illustration techniques concern the placement of the guarantees and the use of modal factors. Make sure the guaranteed columns (values, death benefit) are prominently displayed. They should show the contract imploding if not enough premium is paid to handle guaranteed mortality and guaranteed interest rates. Many illustrations are produced showing an annual premium. When the policy is delivered, the premium is sometimes paid monthly. If the contract is a fixed premium policy, the correct premium has to be paid for the mode selected. If the contract is universal life, there is no "correct" premium; it will accept anything over the contractual minimum. If the premium comes to the company on a monthly basis, however, the interest earned will not be anything like the interest shown on the illustration. Therefore, the cash value will be lower, and the contract values will not grow as quickly or might even get exhausted (forcing a lapse in coverage). Make sure the correct payment mode is indicated when an illustration is prepared.

THE PRESENT

Where have all these tricks and gimmicks led us? Today, words like "deceptive" and "misleading" almost always precede "sales illustrations" in news stories. In part, certain companies and individuals have set this tone. However, you must also recognize that the majority of insurance professionals want to present accurate and fair projections to their clients. We must look at our economy and the environment within which the industry has worked to fairly view the picture.

We've dealt with market interest rates falling, the stock market crash of 1987, questions about asset quality and real estate exposure, the DAC (Deferred Acquisition Costs) tax, and a number of spectacular insurance company failures. The bottom line? As a reflection of the total economy we operate within, companies have had to make the nonguaranteed elements of the insurance contracts less favorable to policy holders. The projections of the previous 10 years are not going to come true. The investment returns are down. Granted, they're still well ahead of the guaranteed numbers, but they are not the same as the projections indicated in the sales illustrations.

We're already seeing two problems from the early illustration wars. There were a lot of contracts sold on a "vanishing premium" basis. Dividends or excess interest were supposed to produce enough value to take care of the premium charge. From the mid 1980s to now the assumed dividend interest crediting rate has dropped 300-400 basis points and current interest rates have dropped more than five percent. The "vanish" period has been lengthened--that is, it takes more years of payments to get to where you can stop premium payments.

Also, a lot of second-to-die policies were sold in the last decade. People are more educated about their estate tax exposure, and are preparing for that cost with the discounted dollars of insurance. There is no more permanent need than the need for estate tax protection, and the need does not go away until you die. Still, many

policies have been sold using a term blend to drive down the cost and win the sale. That was easy when interest rates were high. Projecting increasing dividends or excess interest would have handled the increasing term costs and either kept the premiums low or helped them vanish. Today, with rates and dividends down, they may not do either.

Consumers may be suffering from a convenient case of amnesia regarding the policies they bought. They forget the difference between guarantees and projections. This amnesia is unfortunate in a period of declining interest rates, since it leads to consumer complaints being filed with insurance departments and elected representatives. More scrutiny gets applied to the whole sales presentation process.

What are some of the common problems in today's illustrations? Some companies believe they will make more sales if their illustrations are more aggressive. They continue to make unsupportable assumptions about investment returns in the future and projected dividends. There are still persistency bonuses being shown, exaggerated mortality assumptions, and lapse supported returns being projected. Today's computer technology is making "what-if" scenarios easier to show, but these are mostly done for sales purposes, not to educate the consumer about the policy. It is important to try to identify those companies who attempt to fairly portray experience in their illustrations.

In the early 1990s, Sen. Metzenbaum (D.-Ohio) championed the concerns of the consumer in Congress. The NAIC continues to push for understanding and completeness. The measures to protect the consumers are somewhat frightening: an early draft of a bill would have allowed insurance commissioners to require insurers with "non-supportable" illustrations to pay based on the illustration most favorable to the consumer. There are already questions on the insurance company's annual statement for the actuaries asking first about the ability to continue supporting current scales of dividends and nonguaranteed elements if current experience doesn't change, and, second, if any of the bases for current scales assume experience factors more favorable than current experience.

It is very important to remember this: people can illustrate anything they want, but actual results depend on actual experience. And that brings us to . . .

THE FUTURE

To begin this discussion, it may be helpful to bear in mind some advice from Jack Bobo, delivered in 1988 to the annual meeting of the National Association of Life Underwriters:

> "We also need to find a way to deal with the computer mania that is infecting our sales illustrations. The current emphasis on investment results puts us on a collision course both with other intermediaries and our policy holders' expectations. If we cannot find a way to put limits on our freedom to illustrate

anything we can imagine, then surely there is someone who will do it for us. The high interest crutch has departed for the moment, and it's time we rehoned our selling skills in appealing to need over greed."[6]

The "flight to quality" push at many companies (very conservative investing to reduce perceived chances of company failures, with a commensurate drop in investment return) along with the overall drop in interest rates have combined to produce more of a level playing field on illustrations. The high credited rate on a product now gets questioned more than a low one. People (both brokers and clients) are starting to appreciate that the highest 20th year values do not necessarily show the best product. There are at least three ways illustrations (and their presentation) will change over the next few years.

THE ILLUSTRATION QUESTIONNAIRE – IQ---More companies are now dealing with the Life Insurance Illustration Questionnaire (IQ) developed by the American Society of CLU & ChFC. This is a series of 25 questions to be answered by the insurance companies. These answers help the agents and brokers understand the nonguaranteed elements of the contract they are presenting. They can explain to their clients how changes in mortality, interest rates, investment gains, persistency and expenses can change what was illustrated on the original projection. If the agents or brokers understand the variables in several contracts, they are better positioned to explain the differences and the potential problems in those illustrations.

How does the IQ look at some of these nonguaranteed features? On mortality, for example, it looks at whether future improvement is anticipated, and asks the following questions:

- ☐ Are the mortality rates underlying the illustration lower than actual recent company experience? Define actual recent experience (e.g., company experience for the last 5 years).

- ☐ Does the illustration assume mortality improvements in the future? If so, describe.

- ☐ Do the mortality rates or cost of insurance charges include some expense charge? If so, describe.

[6] W. Stoltzmann,"Sanity in Policy Illustrations," Best's Review, 143. Oldwick, NJ: A.M. Best Co. Inc., June, 1988.

There is a section on interest or crediting rates. They try to determine if there are any assumptions about future improvement in investments, if the rates are new money or portfolio, and whether there is any "bonus" interest credited in the future. Those questions include:

- ☐ Describe the basis of the interest rate used in the dividend scale or credited in the illustration. Include in the description whether the rate is gross or net of expenses and/or margins.

- ☐ Are the interest rate(s) reflective of the earnings on all invested assets? A portion of the assets? New investments over certain number of years? (If so, specify number of years). An index? (If so, specify).

- ☐ Do the company investment earnings' rates which are required to support the interest rate used in the dividend scale or credited in the illustration at any policy duration exceed the company's actual current earnings' rate on the investment segment backing that block of policies?

- ☐ Does the interest rate used in the dividend scale or credited in the illustration vary between new and existing policies?

- ☐ Do the interest rates used in the dividend scale or credited in the illustration vary by policy duration?

On expenses, the IQ tries to determine if all policies will be treated consistently:

- ☐ Do the expense charges used in the dividend scale or charged in the illustration reflect actual recent company experience? If so, what is the experience period? If not, describe the basis.

- ☐ How are investment expenses and taxes assessed?

- ☐ Are expense charges used in the dividend scale or charged in the illustration consistently determined for new and existing policies?

The section on persistency looks at whether illustrations are "lapse supported" (assuming there will be fewer policies in later durations because of early lapses; the remaining policies get any bonuses that are paid) and whether there are interest or mortality bonuses:

- ☐ If the actual persistency is better than that assumed, would that negatively impact illustrated values?

- ☐ Non-guaranteed persistency bonuses are amounts illustrated as being paid or credited to all policy holders who pay premiums (sometimes a minimum specified amount or more) for a specified number of years. Does the illustration involve such a bonus?

- If so, what is its form (e.g., cash amount, additional interest credit, refund of mortality or loading charges)?
- What conditions must be met to pay or credit the bonus?
- Is there any limitation on company discretion in deciding whether to pay or credit the bonus?
- Does the company set aside any reserve or other liability earmarked for future bonuses?

☐ Does the illustration include a guaranteed bonus?
- If so, what is its form (e.g., cash amount, additional interest credit, refund of mortality or loading charges)?
- What conditions must be met to pay or credit the bonus?
- Is there any limitation on company discretion in deciding whether to pay or credit the bonus?
- Does the company set aside any reserve or other liability earmarked for future bonuses?

The second series of changes in the world of illustrations could be legislatively mandated. The National Association of Insurance Commissioners (NAIC) has been working on model regulations designed to make illustrations understandable and helpful to the consumer. In the spring of 1994, the Life Insurance Illustration Disclosure Subcommittee presented a draft of a model regulation. Although it was not accepted at that time, but a description of the tone may be helpful to you.

The draft did not use historical performance on showing values; rather, the death benefit was supposed to be the primary benefit of the contract. There would have to be an actuarial sign-off every year that the interest rates being shown were reasonable. You'll find more on the NAIC situation toward the end of the chapter.

The National Association of Life Underwriters (NALU) **(now known as the National Association of Insurance and Financial Advisors (NAIFA),** along with their national lobbying group in Washington, D.C., has played a prominent role in the whole illustration scenario. In October 1993, NALU made the following statement to the NAIC group dealing with illustrations:

> "NALU applauds the National Association of Insurance Commissioner's (NAIC) efforts to deal with the problems associated with life insurance illustrations. Agents are usually the first to hear about or hear from disappointed policy holders; by then whatever damage that will be done has usually already been done. It is our strong desire to make the process of purchasing and owning life insurance more understandable, not necessarily to make the process simpler. Life insurance is a sometimes complex product, unlike a pure investment product such as a mutual fund. Life insurance has been sold for many years with the aid of sales illustrations that were formerly called "ledger statements." The sales illustration as a tool needs reform to more accurately convey "how a policy might work."

"NALU wants to strongly state at the outset that it does not condone the use of sales illustrations by themselves to compare one policy to another. They are simply inadequate to accomplish that task. But sales illustrations can accomplish the useful task of illustrating to the consumer how a policy works. With the below recommended reform, the consumer will be in a better position to understand and to make an informed purchase decision."

These are the NALU recommendations in a nutshell:

1. Consumers must receive illustrations of values that insurers, at the time of presentation, reasonably expect to support . . . If the company is unable to provide such an illustration then a statement must be prominently displayed on the illustration to the effect that it does not meet this requirement.

2. Consumers must be made aware that current illustrative results are not a prediction of future values, but rather a snapshot of how the policy would work if current scale were to remain unchanged. Sensitivity to change can be accomplished by showing three columns of values: guaranteed, current and current minus 1percent (100 basis points). If the policy is particularly sensitive to changes in non-guaranteed elements other than interest, such as mortality, this fact should also be disclosed.

3. Consumers should sign a disclosure statement whereby they acknowledge that they have read the illustration, and understand that non-guaranteed elements and dividends are not guaranteed. The agent must also sign the disclosure statement verifying that he or she has explained the guaranteed and non-guaranteed policy elements.

4. Sales illustrations should not be used solely to compare policies. Life insurance policies are complex financial instruments, which generally contain both guaranteed and non-guaranteed elements. A sales illustration may be helpful in understanding how a particular policy performs under specified circumstances. It is not feasible, however, to use sales illustrations alone to determine whether one policy is a better buy than another.

5. Consumers must receive descriptions of all policy types and all riders integral to the product being illustrated.

6. Consumers should receive illustrations that show year-by-year values for the first 20 years, plus years when significant policy changes may occur, such as premium reappearance. In addition, they should receive illustrated values for ten year period increments to maturity. The figures should be rounded down after year 10 from inception of the policy to the lower hundred dollars. The years illustrated are

important to demonstrate to consumers when major changes to policy values might take place and the rounding down lessens the impression of precision.

7. Consumers considering illustrations that demonstrate vanishing premiums should receive adequate disclosure of the vanishing concept. The illustration will show guaranteed and non-guaranteed elements and dividend and excess interest values based on a specific premium pattern and the premiums necessary to maintain the original death benefit to maturity for all years under guaranteed assumptions, subject to the maximum premium allowed under IRC Section 7702 (the Internal Revenue Code definition of life insurance).

8. If consumers are considering illustrations that demonstrate second-to-die policies, they should receive information on the cover page as to whether the policy values change at the first death and, if so, how they change.

9. If consumers are considering illustrations that demonstrate "blended" or "modular" policy/rider combinations, they should receive clear disclosure of the modular structure in the illustration.

10. In order for consumers to understand changes that have taken place which affect their policies, and how to use their policies through changing times to achieve desired results, policy holders or their agents should be able to receive in-force policy illustrations upon request.

11. If an agent provides the buyer with a self-prepared or third-party vendor software illustration, it must be accompanied by a company-prepared or endorsed illustration, if available, or the agent's assurance that the third-party vendor's illustration accurately reflects the policy's guaranteed and non-guaranteed values based on current scale.

12. NALU has referred to the Actuarial Standards Board a request for actuarial standards encompassing more precise definitions and more detailed methodology governing the terms "supportability" and "current experience."

13. The cover page for any illustration should contain the annual premium necessary to maintain the policy to maturity based solely upon the guarantees in the policy. This will assist the policy owner in understanding the differences between guaranteed and non-guaranteed policy features.

In February of 1995, there was a further meeting of the NAIC Life Cost Disclosure Working Group. They considered certain recommendations from a subgroup. In a nutshell, they recommended that every illustration include:

1. Two parts to each illustration: an introduction (explanation) including a numeric summary, and a tabular display of policy values and benefits.

2. A narrative section describing the policy itself.

3. A description of the contents of the illustration in the narrative section.

4. Information about the categories an applicant (age, sex, rating class) can be in, and a discussion of any option selected (dividend option or death benefit option) which impacts the premium, values or benefits shown. A numeric summary of values and benefits must show guaranteed scale, midpoint scale and disciplined current scale, in that order.

5. The "guaranteed death benefit" as the initial specified amount of coverage.

6. Sufficient information to identify the client and the illustration in question.

7. Guaranteed values and benefits shown before non-guaranteed ones.

8. Writing and numerics so that, if it is a flexible premium policy, and either the planned premium or the amount of time it is to be paid are not sufficient to carry the policy to maturity at guaranteed interest and other charges, that is shown. If it is a fixed premium policy, if the non-guaranteed elements (like interest or dividends) are used to reduce out-of-pocket costs, this must be shown on the guaranteed, midpoint and current scales (how the premium could change, or the number of years to pay could vary).

9. Applicant-specific information shown in close proximity to displayed values and benefits.

10. An additional page or pages showing state-required or other important information (cost indices, MEC premiums, guideline premiums, etc.).

This is a very timely topic, and one that is still evolving. It is likely that the industry will eventually end up with rules and regulations much like those proposed by the NAIC.

In sum, there are five steps in the consumer decision-making process when purchasing life insurance:

1. Establish the need/identify the problem
2. Agree that life insurance is the right solution to the problem
3. Decide what kind of product best addresses that particular need
4. Pick the right company to provide that product; and
5. Decide how the product fits into an overall financial plan for premium payment.

Illustrations need to be used to show how the policy can work, not only as predictors of future performance. We can't stop at mere disclosure; we need to move to explanations and understanding. This cannot be a passive process, but rather an active process in which we all need to be involved. We can begin the process of illustration integrity ourselves, or we can have a legislative solution forced upon us.

X. SERVICE: DURING AND AFTER THE SALE

Selling a case, underwriting the case, and placing it in a "paid-for" status are all very important. It's how we all get paid and what keeps the insurance companies in business. Still, a very important piece of the insurance transaction is the service we render after the policy is delivered. A lot of things can happen to necessitate changes on a policy: name changes, address changes, beneficiary changes, loan requests, face amount increases/decreases, conversions, payment of premiums, surrenders (partial or complete), duplicate policy request and reinstatements.

Though the bulk of the compensation received by the Agent, and in turn by the General Agent, is received in Year One of the policy, a very important part of a General Agency's income is derived from renewals and service fees. Renewals account for a smaller percentage of the premiums received on inforce, renewing contracts. Service fees paid along with, or instead of, renewal commissions help compensate a Brokerage General Agency for the servicing of the inforce book of business.

Every insurance company has a division called Policy Owner Services or Customer Relations, or some similar derivation of the name. Different companies, of course, call the area different things, but the essential role of the department is to provide assistance to all the customers of the company. These customers include agents, General Agents, policy owners, beneficiaries, as well as internal customers (other employees). Typically a broker responds to a client's service request by calling the Brokerage General Agency he placed the case with. The people at the agency may handle the request with the insurance company, or may advise the broker to call the company directly.

The person handling that agent's request is expected to provide service that is complete, accurate, prompt, confidential, and courteous. Agency employees have to work with customers of wildly varying levels of sophistication regarding the products and services in question. And, since people won't generally keep products if they're not treated well when they have questions, all of the activities of the team in this department have a direct impact on the general agency's efficiency and, ultimately its profitability. Service activities have a selling impact as well. Good service could encourage existing brokers to sell more with your agency, and to refer their friends and acquaintances to the agency as well.

Not only must an agency employee have excellent communication skills, but also each person must be able to confirm his activities, from writing of the policy through follow-up correspondence and file documentation. In addition, a customer service person needs to understand the products currently marketed by the General Agency. Likewise, a working knowledge of what was sold in the past can be helpful is ideal.

Questions directed to an employee of a Brokerage General Agency must be answered correctly, politely, and in a timely fashion. To obtain the information needed to do

this, the Brokerage General Agency staff person may request feedback from the home office.

In the past, the job roles within the Policy Owner Service Area of an insurance company were divided among the staff, with one person designated to manage policy loans, for example, while another person addressed only name change requests. Thanks to technology and the push to do more with less, today's staff cross-train in all functions of the department and individuals are expected to handle the whole gamut of job skills. This adds not only a breadth of skills to the individual's repertoire, but also helps to ensure that questions can be answered by the person who picks up the phone. Some areas are organized by product type, (for example, term products, excess interest products, annuities), others by geography, and others still by different categories, such as customer type. No matter how the department is organized, it is the responsibility of the Brokerage General Agency and its entire staff to get the required information quickly, communicate it to the broker involved, and document that information transfer. Documentation should include the name of the home office employee and the date of the conversation; hard copy should be requested whenever appropriate.

Following is a discussion and clarification of some of the most common policy owner requests.

BENEFICIARY CHANGES—One of the most commonly requested categories on inforce policies is beneficiary changes. The wording suggestions that follow are also applicable to the beneficiary section on the original application. Verify with a particular carrier if the following suggestions are acceptable. There are certain signature requirements that must be met before the request is processed: it must be signed by the owner of the policy, and if the original beneficiary was an irrevocable beneficiary, that original beneficiary must also sign the request. Without required signatures, the company cannot make the change.

An insurance company has to be sure that the person who is to receive the policy proceeds is named or described with enough detail that he can be easily identified should benefits become due to be released. Though it is the role of the Brokerage General Agency to assist the broker in completing an application correctly, it is not their role to provide tax advice or estate planning recommendations. Knowing how to correctly state beneficiary designations can help get cases issued correctly and quickly. Beneficiary designations can be as simple as this:

> *Jane Doe, spouse, date of birth*
> *All the proceeds will be paid to her at the death of the insured.*

When naming two or more beneficiaries in the same class, always show the split as percentages, not as dollar amounts, because the net amount of proceeds may change as a result of loans, surrenders, or face amount decreases. In this case, the beneficiary information might look something like this:

John Doe, father, date of birth, 60 percent
Mary Doe, mother, date of birth, 40 percent.

Do **not** present the information as such:

John Doe, father, date of birth, $60,000
Mary Doe, mother, date of birth, $40,000

Such a request will be summarily rejected.

TWO BENEFICIARIES, EQUALLY:

John Doe, father of the insured, date of birth
Mary Doe, mother of the insured, date of birth, equally, or to the survivor

THREE OR MORE BENEFICIARIES:

John Doe, father, date of birth
Mary Doe, mother, date of birth and
Richard Doe, son, date of birth, equally, or to the survivors or survivor.

THREE OR MORE BENEFICIARIES IN UNEQUAL SHARES:

John Doe, father date of birth, 1/2,
Mary Doe, mother, date of birth, 1/4 and
Richard Doe, son, date of birth, 1/4.
The share of any deceased beneficiary will be equally paid to the survivors or survivor.

UNNAMED CHILDREN BORN OF THE INSURED:

Lawful children of the insured, equally, or to the survivors or survivor.

UNNAMED CHILDREN BORN OF A PARTICULAR MARRIAGE:

Children born of the marriage of the insured and Jane Doe, wife, equally, or to the survivors or survivor.

UNNAMED CHILDREN (INCLUDING LEGALLY ADOPTED CHILDREN):

Children born of the marriage or legally adopted by the Insured and Jane Doe, wife, equally, or to the survivors or survivor.

JOINT TENANTS WITH RIGHT OF SURVIVORSHIP:
On the death of one joint tenant, the tenant's share of the property goes automatically to the survivors or survivor.

John Doe and Jane Doe as joint tenants with right of survivorship.

IRREVOCABLE BENEFICIARY:
A beneficiary whose interest in the policy cannot be changed or reduced without consent.

John Doe, Irrevocable Beneficiary

BANK LOANS:
At death, the bank will receive payment for the outstanding balance, with the rest going to the named beneficiary.

First Connecticut Bank, as its interests may appear under loan #0000000, dated 00/00/00, with balance, if any, to Jane Doe, spouse, date of birth.

If all or part of the coverage is for a bank loan, the bank may be better served with collateral assignment rather than being named a beneficiary. Most companies will send copies of correspondence, including premium notices, to collateral assignees.

BUY-SELL AGREEMENT:

Trustee of the Buy-Sell Agreement between John Doe and Jane Doe under the agreement dated 00/00/00.

COMMON DISASTER CLAUSE:
This comes into play when two people die under conditions where it is impossible to determine which one died first. Common disaster clauses can be for any number of days under 6 months. Most companies try to discourage periods longer than that.

Jane Doe, wife of the insured, date of birth, if she survives the insured for a period of ____ days; Otherwise, children born of the marriage of the insured and said wife, or the survivors equally, or the survivor.

INDIVIDUAL CREDITOR:

John Doe, creditor, under a line of credit (or revolving loan), balance, if any, to Jane Doe.

ESTATE OF THE INSURED:

Estate of the Insured.

SPLIT DOLLAR BENEFICIARY:
There are many ways the proceeds can be split under this kind of arrangement. Remember that the purpose of any beneficiary designation is to establish with substantial certainty who will receive what from the proceeds.

The greater of the sum of the premiums paid or the cash accumulation account to ABC Corporation; balance to Jane Doe, wife of the insured, date of birth.

TRUSTS:
In most cases, the trust should be signed before the date on the Part I application and the issue date of the policy. If it can be shown that the insurance application preceded the establishment of the trust, the IRS might try to include the proceeds of the policy (in the irrevocable trust) in the estate of the insured for three years after the trust date. Remember, the purpose of the trust is to avoid having the insurance proceeds included in the estate for taxation purposes; consult the home office for specific handling directions.

Trustee of the John Doe Trust under Trust Agreement dated 00/00/00

Trustee of the John Doe Irrevocable Trust under Trust Agreement dated 00/00/00

John Doe, for the benefit of Jane Doe and John Doe (informal trust arrangement)

Trustee of the John Doe Living Trust under Trust Agreement dated 00/00/00

UNIFORM GIFTS/TRANSFERS:
Gifts can be made to minors by transferring property under either the Uniform Gifts to Minors Act (UGMA) or the Uniform Transfers to Minors Act (UTMA). Under either Act, there may be restrictions as to who can be named owner or beneficiary of a life insurance policy.

John Doe as Custodian for Jane Doe, minor, under the (state) Uniform Gift to Minors Act
Or
John Doe as Custodian for Jane Doe, minor, under the (state) Uniform Transfers to Minors Act

PER STIRPES.
A Latin phrase meaning "by the branches," this distribution method comes into play in the event of the death of a named beneficiary. If that person, possibly the child of the policy holder, died, but had children of his own, his share would be divided among his children. It keeps moving through the branches of the family. Contrast that with per capita, or "by the heads." If this were the distribution method, each child who survived that father would get a share equal to that of the aunts and uncles. "Per stirpes" is the more popular method of distribution.

To all children of this marriage and to the survivors of a deceased child, per stirpes.

OWNERSHIP CHANGES AND TRANSFERS FOR VALUE---Sometimes you will be asked to adjust the owner designation on a contract. Since there might be adverse tax consequences if the transaction is not handled correctly, a warning is appropriate. Please remember that the only people licensed to give legal advice are lawyers. Anyone else who does so is "engaged in the unauthorized practice of law" and is subject to criminal sanctions in most jurisdictions.

At the same time, it is your job to help the broker as much as possible. You have to walk a fine line. Two common subjects that fall under the category of ownership changes involve **collateral assignments**; the first are transfers for value and the second, Section 1035 exchanges:

TRANSFERS FOR VALUE---As a general rule, proceeds from a life insurance contract (the death benefit) are income tax-free to the beneficiary. Transfer for value problems may arise, however, if a policy is sold or otherwise transferred for valuable consideration. For example, if I own a policy and change the ownership to you, I've either made a gift to you, which has its own set of gift tax implications, or transferred the contract for value. If a transfer for value takes place, only the amount of the consideration paid, plus any future premium payments, will be treated as a tax-free death benefit. The difference could be a lot of money.

Of course, not all transfers cause a problem. As with anything tax-related, there are a few routine exceptions. There is no problem when the sale or transfer is made:

- To the insured
- To a partner of the insured
- To a partnership in which the insured is a partner
- To a corporation in which the insured is an officer or a shareholder
- To a spouse
- Partly by gift

Even a fairly casual, routine request to change owners on a policy can have serious financial implications. Remember the Three Year Rule on ownership changes: if a policy owner dies within three years of changing the owner on a life insurance contract in an attempt to keep the proceeds out of his estate, the proceeds will be included in the estate for purposes of calculating the federal estate tax liability. If the broker and the policy owner want to change owners, and the change does not fall cleanly into one of the transfer for value exceptions above, refer the request to the law department of the appropriate insurance company.

SECTION 1035 EXCHANGES---Section 1035 exchanges deal with the exchange of an old policy for a new one, and usually involve transferring the cash from the old policy to the new one. In some instances, the surrender of an old policy and the subsequent purchase of a new one can give rise to a taxable event. For instance, if the surrender value of the contract exceeds the sum of the premiums paid, the excess amount, or the gain in the contract, is treated as ordinary income. Section 1035 of the Internal Revenue Code offers a way to exchange the old contract for a new one so the recognition of the gain is deferred until a later date when the contract

is surrendered. If the contract is held until the death of the insured, the gain is never recognized.

There are strict "ordering" rules involved with these exchanges: you can exchange some contracts for others, but not to certain other policy forms. The ranking is as follows: LIFE, ENDOWMENT, ANNUITY. An owner can exchange a life contract for another life contract, for an endowment contract, which are rarely issued anymore, or for an annuity contract. An endowment contract can be exchanged for another endowment contract or for an annuity contract. An annuity contract can only be exchanged tax-free for another annuity contract. Remember L-E-A. You can exchange down the ladder (or on the same line) but not up the ladder.

LIFE,
ENDOWMENT,
ANNUITY

If a broker is trying to replace one contract form with another, the exchange rules become very important. In this case, always check with the Underwriting/New Business department of the two companies involved to see what procedures need to be followed. In general, the policy owner assigns the old contract to the new company; the new company then surrenders the contract and places the proceeds into the new contract. The policy owner might receive a 1099 form (taxable income) early next year, but will be able to show on his tax return that the transaction was a nontaxable exchange under Section 1035.

Some 1035 exchanges can transfer tax benefits available under old policies (but taken away by subsequent legislation) to the new contract. Two examples of this are single premium whole life contracts and certain pre-1982 annuity contracts. In some cases a client may want to affect a 1035 exchange from a term contract to a new permanent plan. The premiums paid on the term policies may constitute a basis that can be transferred to the new contract. Some companies may not allow this kind of 1035 exchange, if they believe that a term contract does not have any basis. Another "special" 1035 issue is the transfer of outstanding policy loans during a Section 1035 exchange. Some companies will assume the outstanding loan, others will not. Always ask your home office for advice on any one of these types of transfers.

Again, no one wants you to be a lawyer. You, along with your peers in the Policy Owner Service department at the insurance company, need to be able to identify potential problems. Your job is to make sure the broker or agent have thought through the change they are requesting; leave it to the legal experts to figure out the "right" thing to do.

ADDRESS CHANGES---Address changes can occur for a number of parties to the contract, from the insured or the premium payer, to the owner of the contract, the

assignee, or an irrevocable beneficiary. It is important for the company to have accurate addresses on all these parties to avoid delays in the event of a payout or to prevent a lapse in coverage.

CHANGES OF MODE—Sometimes the premium payer wishes to move from one mode of premium payment (annual, for example) to another. This form allows the payer to do so. It also points out that one of the premium due dates has to be the policy anniversary and explains what information is required to begin a "Pre-Authorized Check" mode for the policy if the premium is being automatically subtracted from a checking account each month. Changes in mode should always be requested by the owner in writing to avoid a possible lapse during the process of making the change.

REQUEST FOR A DUPLICATE POLICY—Sometimes people lose or misplace their insurance policies. This form allows them to request a duplicate policy, tells them they may be charged for this, and points out that the old policy will no longer be in effect.

NAME CHANGES—As with address changes, names change requests are very common, both for individuals and for businesses. People get married, divorced, or legally change their name, and when they do, their life insurance policy must be revised accordingly.

POLICY LOAN REQUESTS—Policy holders may request policy loans by completing this form. In this transaction, the policy values become the collateral for the loan. If the policy is ever surrendered, the company first subtracts the amount owed, then turns over the balance. The death benefit is reduced by the amount of the loan and can be further reduced by any interest not paid on the loan amount.

POLICY CONVERSIONS—Many term policies contain a conversion privilege that gives the owner the right to move from term (temporary coverage, often with increasing costs) insurance to permanent coverage with growing values, level costs, and higher premiums. The owner can do this without showing evidence of insurability (no underwriting). Some companies will convert a waiver of premium rider on a term policy without evidence of insurability, while others will not. Conversions are also allowed from employer-sponsored group plans to individual coverage if a person is leaving that employer. With some companies, the converted policy does not start a new suicide or contestability period; the balance (if any) of the original period will still apply. However, since a new contract with a new policy number is issued under a conversion, many companies initiate a new suicide and contestable period based on the new policy date. Be careful to verify each company's procedures and notify the broker of relevant sanction during the conversion activity.

Some companies offer a "conversion credit" when the client moves to a permanent plan. This reduces the cost of the permanent policy in the first year. With certain carriers, this credit can be an amount up to the full term premium from the preceding policy year. You need to check the conversion program of the company that issued the term contract. Usually the Policy Holders Service area can tell you what the

conversion credit will be. Some companies pay a new first year commission on the conversion, making conversions a lucrative source of income for people who write a lot of term insurance, but others only pay commissions on the new, net premium received by the company. A broker should be told if this is the case prior to submitting the conversion application. Verification of whether the conversion credit lessens the fully commissionable premium should be made, too.

EXTERNAL CONVERSION PROGRAMS---In addition to submitting a term case to the original writing insurance company, there are other special programs available in the marketplace which offer conversion guarantees to convert one company's term products into another's permanent product line. Such programs typically limit such guarantees based on the length of time the term was inforce, the underwriting classification issued previously, and the original writing company. Besides reviewing program highlights, attention should be focused on the financial ratings of the companies involved. For example, moving a term contract from a highly rated company with a strong permanent portfolio for conversion to a company less strong financially just so the broker can maximize commissions might not be viewed by the client as sound planning advice.

FACE AMOUNT CHANGES---Some policies offer the policy owner the option to increase or decrease the insurance amount. A policy owner may want to decrease a coverage amount because the policy costs too much, or because he or she doesn't need as much coverage as before. A change like this is usually allowed after the first year of coverage (check with the issuing company). The change is requested by completing a policy service request form. Some companies may even allow a decrease on a term contract, even though the policy form may not specifically allow for the change, or on a whole life policy, with a proportionate share of the policy values returned to the holder. Changes are most often seen on universal life or variable universal life policies.

Universal and variable universal policies also allow face amounts to increase. Be careful though, as many companies will require evidence of insurability (underwriting) before allowing the increase. Such a policy change could bring about new suicide and contestability periods on the increased amounts. The broker and the client need to be aware of these requirements so they can decide if they still want to proceed.

EXCHANGE OF INSUREDS PROVISION—The “exchange of insureds" provision is most commonly seen in business setting. For example, if Insured A leaves the company, Important Person B may be hired for that job. Rather than surrendering the first policy and incurring the acquisition costs on a new contract, the company could exercise this exchange of insured provision (if available). The new person would be underwritten, and the premium and contract values adjusted to reflect the new life.

THE GRACE PERIOD—The grace period on a contract is that period of time following the premium due date during which the policy remains inforce, even though the premium has not been paid, and the premium can still be paid without the company refusing to accept it. The coverage and policy benefits continue during that extra

time (usually 31 days); if the owner pays prior to the end of the grace period, there is no lapse in coverage.

If the insured had a heart attack and died during the grace period, the company would pay the claim (absent other unusual circumstances). The premium due but not paid would be subtracted from the death benefit. Thus, the company gives latitude to policy owners regarding their premium payments.

A policy lapses when premiums are not paid when due or during the grace period. If the policy is one which includes the option not to pay, such as universal life, the policy would not lapse unless there were insufficient funds available within the contract to cover minimum costs of coverage.

REINSTATEMENTS---If a policy lapses and is terminated, no more benefits are due or payable under the terms of the contract. The broker and policy holder may request reinstatement (putting a lapsed policy back into premium paying status or inforce) and may have to show evidence of insurability. Payment of all past due premiums (plus interest) is usually required, and medical evidence is provided at the expense of the policy owner. You need to check with the company for specific requirements needed to reinstate the policy in question. Lapsed policies must be reinstated within a reasonable period of time, as determined by the company.

NON-FORFEITURE OPTIONS---To provide protection against forfeiting accumulated values upon lapse or surrender, contractually guaranteed options called non-forfeiture options are available. In a permanent policy, for example, the accumulated values can be used to provide a variety of benefits, including:

- Extended term insurance. In this case, the contract continues without the payment of premiums and continues until the cash is exhausted due to the company deducting annually increasing term charges.
- Reduced paid-up insurance is the second. The accumulated cash is used to purchase, on a guaranteed basis, a pre-determined amount of coverage. It is generally a lot lower than the original insurance amount. This benefit will continue to the death of the insured.
- The policy may be surrendered for the available cash value. This is a full surrender, and there may be income tax consequences to the owner. Some participating plans will offer what is called a terminal dividend which may, under certain circumstances, offer an increased cash value on surrender.

In addition to these common non-forfeiture options, if a contract has accumulated cash values, and a premium is not received by the end of the grace period, an automatic premium loan may be used to maintain coverage as long as possible. The automatic premium loan feature is one requested by the policy owner.

RE-ENTRY OF TERM PLANS—Many term contracts offer the opportunity for an insured to show medical evidence at a specified time, typically five or 10 years after the policy issue date. If the medical evidence is satisfactory to the company, the policy owner may qualify for lower rates for the coverage. The re-entry process varies from

company to company. First, the requirements needed to show good health will vary from carrier to carrier. Many insurance companies will simply ask for a new application and the usual medical requirements. Additionally, medical requirements for re-entry are usually provided at the policy owner's expense. You should verify if the company will pay new commissions to the broker for re-entry cases. Also, it may useful to ask if the company will issue a new contract upon re-entry, or if they merely adjust the premium on the inforce plan? Another common question that should be is asked is this: Does the insured have the option to apply for a different term contract currently being offered by the carrier; for example, a 10 or 15 year term instead of the inforce five year term?

If a new contract is to be issued, be sure to verify with the company, then inform the broker if the proposed re-entry will trigger a new suicide and contestability period. As always, careful documentation of this communication should be kept on file.

In the opinion of most companies, it is not their responsibility to notify a policy owner of re-entry eligibility when it occurs. Instead, it is the responsibility of the policy owner (and insured) to request re-entry. Some brokers and Brokerage General Agents track re-entry dates, others do not.

POLICY MATURITY---What happens if a permanent life contract "endows," or reaches the maturity age shown in the contract?

Typically life insurance proceeds are payable upon the death of the insured. There are certain contracts, however, that establish a certain date (for example, age 95 or 100) at which time the contract values must be paid out. In a whole life contract with fixed values, the cash accumulated in the contract generally equals the face amount at that maturity date. In a participating contract or a contract which features excess interest credits (EIWL or UL), the accumulated cash could be any figure, depending on how the investments performed while the contract was inforce.

At maturity date, the owner gets a sum of money. From a tax perspective, this amount is not treated as proceeds of a life insurance policy, so **it is not income tax free to the recipient**. Additionally, the amount is paid to the contract owner, not to the named beneficiary; therefore the money has not gone to the person selected to receive the proceeds. The amount is treated as ordinary income to the extent it exceeds the basis in the contract.

The taxable income received by a policy owner at maturity can conceivably be a large figure, depending on the size of the contract, the sum of the premiums paid, and the amounts previously removed from the contract through policy loans or partial surrenders. How have companies dealt with this situation? For new contracts, many insurers no longer put a maturity date in their permanent contracts. At a given age when premium is no longer due (or when there are no "cost of insurance" charges listed in the contract), the policy is "frozen" until the death of the insured. Then the benefits are paid out as death proceeds, and the problems mentioned above do not exist. If there is a maturity date in the contract, some insurers enact this "freeze" on

their own so people don't have this tax problem. Ask the companies you do business with how they handle such a situation, and become familiar with their various permanent policy forms, for both new and inforce cases.

DEATH CLAIMS—When a death claim is filed in the first two years after a policy is issued, the claim is within the "contestable period" and is subject to investigation by the company. You should be sure that the claimant understands that this is a standard practice and does not imply any wrongdoing. Also be sure to explain that the investigation can be speeded up by cooperating and responding promptly to all requests for information. You can assist as well by familiarizing yourself with the claims procedures of the company, and might even consider developing a manual with claims information about each company your office represents. This would help you to anticipate requests from the different companies and would be useful for the claimant and the company, as well. Document everything you do, including keeping written notes of the dates and times of phone calls.

In processing death claims, do not promise a quick or positive resolution to the claimant. While the vast majority of claims are legitimate and payment is made promptly, if the company finds evidence which gives them possible cause to deny the claim, they have the right to investigate in greater detail. The company may deny the claim if they find sufficient cause to do so. If the claim is denied, a lawsuit may be filed by the claimant against the company. Such situations occur infrequently, but your care in dealing with the claimant and the company, particularly giving proper attention to detail and documentation, will help make this a difficult experience and not a disaster.

As you can see, odds are you will get involved in every aspect of the policy after it is put inforce. A lot depends on the professional handling of these requests. Your thoughtful attention to the required forms and signatures is very important. Your work on these policies has a big impact on the success of the Agency, and can encourage future sales from both the broker and the client!

XI. ERRORS AND OMISSIONS: THE WAR STORIES

This is a very important chapter in the Brokerage Desk Reference book. It is critical for us to identify those areas in which problems can arise, and to incorporate preventive steps into the way we conduct our business.

At the same time, it is interesting to see what kinds of problems others have found themselves involved in, so we can be sure not to make the same mistake! After you read these war stories, think through the procedures used in your own office. Is there a smarter way to do things? Are there some controls you could put into place to ensure that certain things must happen, or that others never will?

Some of these cases talk about what the broker did and how the broker was sued. In such cases, if the policy is written through the agency in which you work, there is a good chance your agency also will be named in the suit. The lawyer for the plaintiff will look for any person or entity involved in that case from the very beginning, and will name those parties in the suit. Forget whether the agency did anything wrong: that's something to be decided later. The plaintiff is looking for any potentially responsible "deep pockets" to be brought into the action. So when you see "broker" in the text, understand that the agency could be named as well, and ask yourself if you could have, or should have, done anything differently.

In addition to a Brokerage General Agent needing a strong Errors and Omissions (E&O) contract in place, it is usually important that the agents and brokers with whom you do business be adequately covered for their actions. Many Brokerage General Agents require its brokers have E&O coverage to protect their brokerage activities; there are even some companies that require the same. Experts predict this trend toward mandatory E&O will continue.

The following cases are culled from the files of a broker-administrator of Errors and Omissions coverage and serve as a bellwether for the rest of us. As they say, “watch and learn.” A lot of important lessons can be learned from the experience of others.

BACKDATING APPLICATIONS—An agent had his first appointment with a 29-year-old man and his wife on August 22. During that first meeting, the husband told the agent he had been to the doctor earlier that day. The doctor told the husband he had high blood pressure.

The agent told the clients that if they had met one day earlier, they would not have to report the visit (or the diagnosis) on the application. They agreed it would be easier to obtain the coverage if they backdated one day, to August 21. The agent did this even though the husband said the doctor had prescribed blood pressure medication for him.

Less than two years later the husband had a heart attack and died. The wife filed a claim for the $50,000 of coverage. The insurer denied the claim based on the husband's failure to disclose important medical information on the application. The

wife filed a lawsuit against the agent and the insurance company. The suit was settled for $44,000.

What are the lessons here? First, the agent should have never backdated the application. Things happen when they happen, not the day before or the day after. The truth should always be disclosed on the application. Second, the agent has a duty to disclose medical problems to the insurance company. It is not the agent's job, nor the General Agency's job, to evaluate the risk or to say that high blood pressure in a 29-year-old is not a serious problem. The agent is obligated to disclose facts; the company will evaluate the risk.

FILL OUT THE WHOLE APPLICATION—A 68-year-old male purchased a $50,000 whole life policy. The only underwriting requirement was a health statement completed by an outside paramedical service. The client failed to disclose a preexisting condition with his bladder that may have been cancerous. The agent was not aware of this. Additionally, the agent failed to check on the application that the client was going to drop an increasing term policy since the rates were too high. Thus, this was a replacement policy, and as such, was subject to state replacement laws.

Later, the man applied for another $50,000 of coverage on the new policy, but a medical exam was required. He disclosed his condition (which had worsened) to the doctor. The insurance company advised that it would not issue the new coverage, and they rescinded the earlier policy. Now the man was uninsured.
The man filed suit against the agent, and the case was settled for $25,000.

Many states have regulations requiring special handling of a life insurance application when the policy being purchased is intended to replace an existing policy. Most companies typically require a disclosure statement be furnished to the customer. It's also standard practice to provide notice of the intended replacement to the original carrier. Replacement regulations, as well as the consequences of violating them, vary from state to state.

Do you have a regular procedure for ensuring that all questions are answered on the application? Are replacement forms completed when they should be as dictated by the laws of the state where the application is being taken?

"CREATIVE" ILLUSTRATIONS—An agent was preparing a variable life illustration for a client. The illustration from the carrier showed an assumed eight-percent rate of return that was consistent with long-term historical performance. A disclaimer stating that the rate was not guaranteed and that actual experience could be different was included in the illustration.

However, the agent thought eight percent was a little conservative, and she knew last year's return was 21 percent. She used her own computer to project this 21 percent return fifteen years into the future. This new illustration did not have a disclaimer printed on it, and the agent did not state that the illustration was not a guarantee. Based on the agent's illustration, the client purchased the policy.

The performance the next year was only four percent. The client filed an E&O claim for failure to properly calculate investment/return. The E&O insurer concluded that projecting one year of unusually high return fifteen years into the future was fundamentally misleading. Also, the lack of a written disclaimer made it difficult to counter the client's claim that the rate was guaranteed. The claim was settled with a refund of surrender charges and a payment of the difference between actual policy performance and what the money would have earned in CDs.

The agent erred in several ways. First, she should not have added materials produced on her computer without the express approval of the insurance company. The same rule applies if you work in a Brokerage General Agency, too. There are many approved programs that manipulate figures from the insurer's software into split dollar presentations or deferred compensation illustrations, but this case goes far beyond that situation. In addition, appropriate disclaimers should be printed on any and all material given to the client. Likewise, the verbal presentation should state that projections are not guarantees.

PROJECTION AND CALCULATION ERRORS—In another case, the insurer provided software to its General Agents to calculate premiums for annuities used in structured settlements. The General Agent then asked an office assistant to run the quotes. The assistant entered information incorrectly on one quote causing the premium quote to come out too low. The agent did not notice the error and submitted the application. The insurer did not notice the error and issued the annuity.

Several years later the insurer found the error and made an E&O claim against the agent and the General Agent for the extra premium. The General Agent was responsible for the assistant's error, but there were other issues about the insurer's software design and failure to check the calculation. The claim was settled for a portion of the loss.

A similar situation occurred when an insurer supplied illustration software to a General Agent for both inforce projections and new cases. The General Agency used the software to produce illustrations for one of its brokers to support his recommendation for a client to move from one type of policy to another. Unfortunately, there were errors in the data entry. The illustration was attached to the application, but the figures were never checked by the insurer.

After several months, the insurer discovered the error and told the policy owner the contract would never perform as he expected. The insurer offered the client the option of keeping the new policy or going back to the old one. The policy owner filed suit seeking the extra money he expected because of the incorrect illustration. The claim was settled, and both the insurer and the General Agent's E&O carrier contributed.

Can you check every illustration that leaves the agency? Probably not. Do you have a system in place to spot-check some of the illustrations being prepared? If not, you

should. Do people know enough to recognize an illustration that looks too good to be true? Is your staff comfortable enough to ask questions if they don't understand a particular product or software system, or do they just give it their "best shot" and send the illustrations out? Make sure you're comfortable with the entire illustration process in your office.

TAX LAW CHANGES—In 1984, an agent sold a one million dollar whole life policy to a client. The agent said that premiums would be due only in the first four years. After that, loans could be taken out against the policy values and the client would only have to pay interest on these loans. Prior to a tax law change in 1986, these interest payments were deductible for the insured. The agent told the client that, in the tenth year and thereafter, he could withdraw $45,000 per year from the policy with no tax consequences.

The Tax Reform Act of 1986 changed the deductibility of policy loan interest. The amount that could be deducted was reduced over a period of years, and then eventually eliminated all together. Over a number of years, the interest rates projected on the illustration were not attained and the policy did not perform as represented.

The insured initiated suit against the agent, the General Agent, and the insurer. Resolution is still pending. When you are working with policies that are dependent on tax laws, it is important to give the client as much information as possible about the variables and the impact of each on policy performance. Annual reviews of the policies and discussions of pending legislation may have helped in this situation as well. The client could have been prepared for these changes and had a variety of alternatives explained to him. The client would also have seen the effect of a declining interest rate environment little by little, instead of all at once.

Does your Agency provide policy owner service in a timely fashion? Does it provide the Agent with regular status on inforce cases so the agent can keep clients up-to-date? Some Brokerage General Agents run Continuing Education seminars for brokers (and hopefully some of the staff) to keep people informed about pending and current issues such as taxation. Is that an idea worth considering in your agency?

"VANISHING" PREMIUMS—Finally, a story with a happy ending! An agent sold a "vanishing premium" policy, showing how the use of dividends could make the policy run without additional payments after a few years. All the illustrations were produced by the General Agent using a disk from the insurer, and all had reasonable disclaimers about projections and lack of guarantees. Dividends were reduced and the premium did not "vanish." The client sued the insurer, the agent and the General Agency. In court, the client admitted to reading and understanding the disclaimers. He said the agent's enthusiasm made it sound like the illustration was "almost guaranteed." The court dismissed the case, saying the client's position was not reasonable.

The lesson here is clear: Use the insurer's illustrations, make sure the client has read everything, offer to answer any and all questions the client has, and document **everything** in your file. If you can establish that you have a particular pattern or routine you follow in your everyday duties, and if those practices tend to further brokers' and clients' understanding of the products you're selling, then you've gone a long way toward convincing reasonable people that you've done your best.

DUTY TO NOTIFY—The client was an insurance agent writing a policy on his own life. He named his company and his wife as beneficiaries. He completed his own application, and indicated there were no serious medical problems. No money was submitted with the application. After the exam was completed, but before the policy was delivered, the agent discovered he had a life-threatening illness. He did not notify the carrier. He died six weeks after the policy was issued.

The agent had a duty to notify either the agency or the carrier that he would not qualify for the policy because of this illness. The E&O carrier ultimately settled the case without paying any indemnity, but did incur legal fees of over $300,000. There is an affirmative duty to notify the carrier of any change in the insured's condition (as represented on the application and in the medical exam) prior to the policy being delivered. If conditions changed, this would not be the same risk the insurer underwrote. If the change in health occurs after the policy is delivered, there is no duty to inform, and this would have an impact only on the attempted purchase of more or different coverage in the future.

SURRENDER VALUES—An agent requested that the General Agency provide her with a surrender value for her client's policy. Based on the number furnished to her, the agent advised the client to surrender that policy and purchase another.

Several months later the first carrier discovered a computer error that had resulted in a higher than accurate surrender value. The insurer sued the policy holder, the agent, and the General Agency. It argued that the policy holder was required to return the overpayment. In the alternative, it argued that the General Agency and agent were negligent in not checking its calculations against the policy provisions. The case was settled and the insurer got part of the overpayment back; part from the (former) policy holder and part from the General Agency's E&O carrier.

We all have a tendency to trust the numbers given to us by the home office, at least until we get burned, as in this scenario. Make it a habit to always get information such as this confirmed in writing, with the name of the Home Office employee who gave you the numbers. The General Agent contract under which your agency works may have language that holds the agency harmless in the event of Home Office errors. If not, the General Agent may want to suggest it to the Home Office.

CHECK THAT BIRTH DATE—A broker listed a birth date on the application that showed the client as two years younger than he really was. When the insured died and this was discovered, the insurance company refused to pay the full face amount

($800,000), and reduced the death benefit to $700,000 to reflect the insured's actual age.

The beneficiary sued the Brokerage General Agency for the difference in face amount. The General Agency sued the broker for the failure to correctly list the age, arguing that the broker was the one at fault. The case was settled for just under half the difference.

What can you do in the Brokerage General Agency to help avoid situations like this? Never let the broker give you the applicant's age. Always get the date of birth yourself, directly from the policy holder. Remember, some products are "age nearest," while others are "age last." Some illustration systems require you to input the date of birth; the program determines the appropriate age for that product. The brokers may want to make it a habit to always check the applicant's driver's license. That may still produce an incorrect date, but at least the broker will have established a pattern of checking.

LET SOMEONE ELSE BE THE FINANCIAL EXPERT—The General Agent regularly composed and mailed to his brokers a newsletter showing financial information on life and annuity carriers. He gleaned much of the information from the Best's Rating Service and other financial organizations. However, he put things into his own words and showed only the facts he determined were important.

A broker sold an annuity from one of the carriers discussed in this newsletter. Shortly thereafter, that company went into receivership. The client sued the broker, who sued the General Agent. Fortunately for all concerned, the carrier was purchased by another insurer and reorganized so business could continue. The policy owner was not affected, and withdrew the suit.

There are three items which can be of help to you here. First, if you are producing a newsletter, be sure to quote the rating services directly, so it is clear to your readers that they are relying on the expertise of the rating services, not yours. Also, keep in mind that it is much more appropriate to mail out materials prepared by the Home Offices of the companies you represent. Chances are they will be high-quality, professional pieces that accurately represent your products. Plus, these mailers use precise language that show how the companies want to be portrayed. They don't need or want you to put your spin on it. Finally, disclaimers should be drafted with the help of legal counsel, and should appear frequently and prominently on all of your marketing materials.

There are a thousand other stories about E&O claims, but the moral is, every agency needs to have a system of checks and balances. Look at your practices and procedures. Are they logical? Do enough people examine a transaction to make sure it looks okay? Are your employees getting constant updates to their education and training? Are employees comfortable enough to ask questions about things they're not sure about? And have you put yourself in the shoes of the customer? Does what's being proposed make sense? If not, don't expect your clients to accept it.

Remember, our business is no stranger to legal disputes. Don't put your neck, or your reputation, on the line. Take the advice of the E&O experts who say that a little thinking beforehand can save a lot of problems, time, and money down the road.