Life & Health Skills

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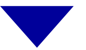

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LIFE INSURANCE

A life insurance policy is a contract under which the first party called the insurer, in consideration of the payment of the premiums, agrees to pay an amount stipulated in the contract to a designated beneficiary upon the happening of a contingency defined in the contract. The contingency is usually the death of the insured or the passage of a definite period of time during the insured's lifetime. The second party to the contract will be the applicant who may be the proposed insured or some other person possessing an insurable interest in the proposed insured's life. The contract first takes effect upon the acceptance by the insurance company of an offer made by the applicant in the nature of an application which will contain medical and other representations regarding the person whose life is to be insured, the completion of a medical examination, if required, and the payment of the first annual premium or an installment premium as the case may be. Thereafter, the contract will continue in force until the benefits mature as long as subsequent premiums are paid.

Nonmedical life insurance is life insurance issued as the result of declarations made by the insured in the application to the soliciting agent. A nonmedical type of application contains a signed statement by the proposed insured giving detailed information about family history, personal health history and current health status. Should this statement meet the company's initial underwriting requirements, the further requirement of a medical examination is waived. The insurer usually reserves the right to require a medical examination. Nonmedical types of applications are generally used only to a certain age, and for limited amounts of insurance at various qualifying ages and, in most cases, where no extensive medical history is apparent which would indicate the applicant might be other than a standard risk.

At the time of signing the application, the applicant may pay the first annual premium or full fractional installment, in which case the agent gives the applicant a conditional receipt. This receipt states that the company accepts the risk from the date of signing the application or completion of all published medical requirements, whichever is later, on the condition that the applicant is found to be insurable by the company according to its underwriting standards for the class and amount applied for. Some companies' receipts provide that interim coverage will be effective in any event until such time that the company formally rejects the application or makes a counteroffer. A few companies provide that a proportionately reduced amount of insurance will be effective even though the proposed insured is found to be insurable only at substandard rates. A "conditional receipt" should never be called a "binding receipt". It should be noted that the insurer may be bound, under many insurance codes, on prepaid applications even though a receipt is not given. Here is one such code section:

“An applicant for an individual life policy who pays the first full premium with the application and dies on or after the date of the application, the date of medical examination, if any, or the effective date of the policy specified in the application, whichever is later, is covered by the policy even if the policy has not been issued and delivered if:

1. The applicant received a company receipt for the payment or the company receives the payment at its home office, branch office or office of one of its general agencies; and
2. The insurance is approved for issuance as applied for by the company in accordance with its regular underwriting procedures.

In such case, payment is made as though the policy had been issued on the date the application was signed. The company may make specific limitations as to the amount of its liability on unissued and undelivered policies, but a statement of such limitations must be included in the applications.

An acknowledgment in a policy or application of the receipt of the premium is conclusive evidence of its payment. If an agent did not collect the premium with the application, the agent should indicate no premium collected. In no case should the agent indicate premium collected, when in fact none was collected, since by law such an indication makes the policy enforceable. In cases where a policy is held to be enforceable because of the agent's statement, when it should not have been enforceable, the agent may be held responsible by the company.”

The law requires that the policy shall contain the entire contract of insurance and that no writing shall be incorporated in it by reference. The result is that in order for the company to rely on the answers in the

application as a defense to a claim during the contestable period, it is necessary to attach the application to and make it a part of the policy. The law also provides that, in absence of fraud, statements contained in the application shall be representations and not warranties.

There are many forms of life insurance contracts, the principal types of which are discussed later. Few states prescribe a standard life insurance policy form and much similarity will be found in the policy contracts of various insurers. The following provisions make for a substantial amount of uniformity among life insurance contracts of the various companies..

LIFE INSURANCE POLICY PROVISIONS

Insuring Agreement - a statement that the insurer insures the insured for the amount of insurance (stated in the policy) to be paid to the beneficiary upon due proof of the insured's death.

Grace Period - a period of time (usually 30 or 31 days) after the due date of a premium, other than the initial premium, during which the insurance is kept in force. In other words, the time allowed after the premium due date in which to pay premiums, with no penalty or evidence of insurability required. Should death occur during the grace period the amount of the premium due and not yet paid will be deducted from the claim settlement.

Reinstatement - except on policies which have been surrendered for cash values, lapsed policies may be reinstated within the time allowed by the policy provisions (usually three years) upon the insured's submission to the company of satisfactory evidence of insurability, the payment of past due premiums with interest, and the assumption of any policy indebtedness which existed prior to the policy lapsing.

Incontestability - a provision which states that validity of the policy cannot be contested by the insurer after it has been in force during the lifetime of the insured for a certain period, not more than two years, except for nonpayment of premiums. It may also include exceptions relating to benefits in the event of total and permanent disability, as well as exceptions relating to provisions which grant additional insurance specifically against death by accident.

NOTE: Policies that have lapsed and been reinstated may again be subject to the contestability period.

Misstatement of Age or Sex - a provision that if the insured's age or sex or both have been misstated, any amount payable shall be such as the premium paid would have purchased based on the correct age or sex.

Suicide Clause - a provision that if an insured dies by suicide within two years (one year in some policies) of the issuance of the policy, the insurer is liable only for the amount of premiums paid. It is designed to prevent an insured from taking out insurance with the intention of profiting by suicide.

Loans - entitles policyowners to make loans against the cash values of their permanent policies, to the extent the company will permit. The policy is held as security. Interest on the loan, at a rate stated in the policy, is payable annually. Interest not paid when due is added to the loan. The policyowner is not under any obligation to repay a policy loan within any period of time; repayment in whole or in part may be made at any time. If the insured dies before a loan has been repaid, the unpaid amount is deducted from the proceeds payable to the beneficiary.

Dividends - a group of provisions, the first of which will state that while the policy is in force, other than as extended term, or reduced paid-up insurance, the divisible surplus of the company will be determined annually and will be credited to the policy on the anniversary date if all premiums are paid to the anniversary date. A notice will be given stating when the dividends will be earned. Normally a policy will not earn dividends in the first three to five years.

The second provision states that upon written request the insured may exercise one of the following options by using the dividend to:

1) Be paid in cash; or
2) Accumulate at interest; or
3) Provide additional paid-up life or endowment insurance; or
4) Reduce premiums; or
5) Purchase term insurance.

If no option is requested by the policyowner in writing, the provision will state which of the above will apply automatically. This provision also deals with the mechanics of receiving the cash that may accumulate at interest, or the surrendering of the paid-up life insurance.

The last provision defines a "postmortem dividend". The term is applied to describe a dividend paid on a life insurance policy after the death of the insured. Some companies issuing participating policies do not pay a postmortem dividend. Usually the purpose is to apportion to the policy any part of the normal dividend that has accrued since the last anniversary of the policy.

Some important points in regards to dividends:

1. A dividend paid on a participating policy is considered a refund of premiums.
2. When a life agent makes a statement illustrating dividends he/she should qualify it by stating that dividends are not guaranteed, nor are they estimated. If the illustration is based on past experience or current dividends, the agent should explain that the illustration is what could occur if the dividends remain unchanged.

Evidence of Contract - states the policy is issued in consideration of the application and payment of premiums as stated in the contract. The policy, together with an attached copy of the application, constitutes the entire contract. This prevents the insurer from using any statements made by the insured but not appearing in the application in defense of a claim. It further states that all statements made in the application will, in the absence of fraud, be deemed representations and not warranties.

Return of Policy - every individual life policy delivered after January 1, 1990 shall have a printed notice that the insured or applicant may return the policy within 10 to 30 days of delivery for full premium refund if not satisfied with it for any reason. The insured may return the policy to the insurer by mail or otherwise at anytime during the period specified in the notice. By doing so, the owner voids the policy from the beginning. All premiums paid and any policy fee paid shall be refunded by the insurer within 30 days from the date the insurer is notified that the insured has canceled the policy.

Nonforfeiture - provisions state that the value of a policy may not be forfeited for nonpayment of premiums after a stipulated number of premiums have been paid. The value of the policy must be in the terms of cash and loan values, extended term insurance and paid-up insurance. Most states make these provisions compulsory in all types of ordinary life insurance, except some types of term insurance, and in all forms of industrial insurance, except that an industrial policy might not provide loan values.

Life insurance policies must contain the following provisions or similar provisions at least as favorable to the insured.

Nonforfeiture Benefits - The policy must state that, upon default in payment of premiums after premiums have been paid for one year, the policy will provide a specified paid-up Nonforfeiture benefit.

Cash Value - The policy must state that upon default of any premium payment after premiums have been paid for three years (industrial-five years) the company will pay a cash surrender value in lieu of any paid-up nonforfeiture benefits.

Automatic Feature - The policy must state which nonforfeiture benefit automatically becomes effective in event of default of premium if the insured has not specifically elected one of the benefits provided.

Cash Value After Paid Up - A policy actually paid up or one continued under any paid-up nonforfeiture benefit becomes effective on or after the third policy anniversary (industrial-fifth) must contain a cash surrender value.

Benefit Tables - The policy shall include a statement of the mortality table and the rate of interest used to calculate the nonforfeiture values. The policy must also contain a table of cash surrender values and nonforfeiture insurance values for each policy anniversary during the first 20 policy years, or the term of the policy, whichever is shorter.

Computation of Values - The policy shall include a brief general statement as to the method of calculation of nonforfeiture values for periods beyond those in the policy. The policy must also contain an explanation of how loan indebtedness or accumulated dividends will affect nonforfeiture values. The policy may include a statement that the insurer may defer payment of cash surrender or loan value for six months after demand.

The Standard Nonforfeiture Law prescribes the method used for calculation of cash surrender values, nonforfeiture benefits, adjusted premiums and values at times other than anniversary date of the policy. Extra premiums charged for substandard risks, double indemnity, disability benefits, and other benefits in addition to life insurance are disregarded in the calculation of cash surrender and nonforfeiture benefits.

NONFORFEITURE DEFINITIONS

Cash Values - the amounts payable in cash by the insurer at the time the insured's surrender the contracts. All permanent life forms and some long-period term forms of life policies must provide for a return to the policyholder in the event of policy surrender of some portion of the excess premiums paid above the actual mortality costs incurred under the particular type of policy. The law permits the insurer to amortize and deduct the expenses incurred to issue the policy.

Loan values - the amount which the company will lend with the policy as security.

Paid-up life insurance - is insurance of the same kind as the policy containing the nonforfeiture provision. When this optional nonforfeiture provision is elected, no further premium payments are required to carry it to normal maturity. The amount of paid-up insurance will be that which the cash value, after deduction of any policy indebtedness, will purchase at the attained age of the insured at net premium rates without loading for expenses. It is often called "reduced paid-up insurance" to distinguish it from insurance which has become fully paid up at the end of the premium paying period.

Extended term insurance - is an optional nonforfeiture provision available to the policyholder, and is usually the automatic provision if the policyholder has not elected one of the other nonforfeiture provisions. It is an extension of the insurance protection against the contingency of death for a stated period of time without further premium payments. If there is no loan against the policy, the amount of insurance will be the full face value of the policy. The period of coverage will be as long a time as the cash value, applied as a net single premium at the insured's attained age, will purchase. Any policy indebtedness will be deducted from the face amount of insurance and from the cash value. This smaller amount of insurance will be provided for a longer period of time than would be the case if the deduction were to be made from the cash value alone. Under an endowment policy, the terms of the death protection cannot exceed the policy's maturity date. If the cash value is greater than the amount needed to extend this protection to normal maturity, the excess cash value will be applied as a net single premium to purchase a small pure endowment which is payable if the insured outlives the term period.

SETTLEMENT OPTIONS

Settlement options are options or modes of settlements contained in the policy, whereby the proceeds, instead of being paid in a lump sum, may be left with the company to be paid in the future either in a lump sum or in fixed or irregular installments. The following settlement options are commonly contained in life insurance policies (examples used are based on 2 ½ percent interest).

1. Installment of Fixed Amount - Proceeds are payable to the beneficiary in installments of a fixed amount until the proceeds, including accumulated interest, are exhausted. Proceeds of $100,000 applied to a guaranteed monthly income of $500 will provide a minimum of 21 years and S months of payments. Any excess interest

dividends will lengthen the period of payment.

2. Installments for Fixed Periods - Proceeds plus interest payable in installments to the beneficiary for a set period of time. Proceeds of $100,000 applied to provide monthly installments for 20 years, will provide $527.00 monthly. Any excess interest dividends will increase the amount of the monthly payments.

3. Continuous Installment or Life Income Options Proceeds are payable to the beneficiary in installments continuing during the life of the beneficiary, but if the beneficiary does not outlive a definite stipulated period, then to a nominee of the insured or beneficiary for the balance of that period. The amount of the installment is determined by age and sex of the primary payee at the time the installments commence. As an illustration, under tables used by some companies, $100,000 proceeds will provide a woman, 62 years of age, a guaranteed life income of $512.00 per month, with 120 monthly payments guaranteed (10 years certain) or $453.00 per month, with 240 monthly payment guaranteed (20 years certain).

4) Interest Option - Proceeds are left with the company for a specified or determinable time to draw interest, with varying provisions for eventual payment of principal to the beneficiary or to third persons. Proceeds of $100,000 will provide $206.00 interest per month, the principal remaining intact.

BENEFICIARIES

A beneficiary is a person or entity designated (named) to receive the proceeds of a policy, upon death of the insured, or maturity of the contract.

Primary Beneficiary - indicates the person(s), organization(s), or estate entitled to receive the proceeds of a life insurance or endowment policy upon the insured's death or upon maturity of an endowment policy, provided that such primary beneficiary is living at the time the proceeds become payable.

Contingent Beneficiary - sometimes referred to as a "secondary beneficiary. is a person, organization or estate designated in a policy (1) to receive the proceeds if the primary beneficiary dies (or ceases to exist) before the insured dies; (2) to receive any unpaid amounts at the death of a primary beneficiary for whom a settlement option was elected by the insured or policyowner; (3) to receive the proceeds or the remainder of the proceeds if for some other reason the primary beneficiary cannot qualify to receive the proceeds.

Joint Beneficiaries - provides for two or more persons or entities to be named to share jointly or concurrently as beneficiaries under a single life insurance policy. The beneficiary provision must clearly state whether they are to share equally or, if not, what portion of the proceeds each is to receive.

Revocable Beneficiary - the insured has retained the right to change the beneficiary at any time without obtaining the consent of the beneficiary (subject to community property laws).

Irrevocable Beneficiary - the insured, during the lifetime of the irrevocable beneficiary, has no further power to change the beneficiary, appoint further contingent beneficiaries, assign the policy, or borrow against the loan value of the policy without the beneficiary's consent. The insured remains, however, the policyholder and is entitled to any dividends payable (and may make such selection or changes in settlement options as are allowable to the insured under the policies). By endorsement, the insured may retain the right to exercise any or all prematurity rights (borrow, assign, etc.) except the right to change beneficiaries.

Spendthrift Clause - a clause providing that the proceeds of the policy or the installment payments shall not be subject to transfer, anticipation, commutation or encumbrance by any beneficiary, and shall not be subject to the claims of creditors of any beneficiary or any legal process against any beneficiary. Its purpose is both to prevent the beneficiary from borrowing against the proceeds or selling his rights to them so as to obtain money ahead of the time intended by the insured, as well as to protect the proceeds against the claims of creditors of the beneficiary.

Common Disaster Clause - is a provision which raises a presumption that the insured is the person last to die when the insured and the primary beneficiary die as the result of a common disaster and the true order of death

cannot be determined. The purpose of the clause is to prevent the insurance proceeds from going to the estate of the primary beneficiary should the insured and the primary beneficiary die in a common disaster.

Short-term Survivorship Clause - is a provision in the policy which postpones the vesting of the benefits of the policy in the primary beneficiary until a specified time (usually 30 to 31 days) after the insured's death and permits such rights to be vested in the primary beneficiary only if the beneficiary is still living at the end of the period specified. The purpose of the clause is to prevent the insurance proceeds from going to the estate of the primary beneficiary should the insured and the primary beneficiary both die within the period selected whether or not the insured and primary beneficiary die as the result of a common disaster.

LIFE INSURANCE PROCEEDS

Proceeds payable to named beneficiaries, other than the insured's estate, and cash values of life insurance policies are, by most insurance codes, made exempt from creditor attachment or execution in legal process to the amount which is purchased by an annual premium not exceeding $500. If the beneficiary is a spouse or minor child, the exemption is doubled. It is noted that the statute exempts both the cash values while the insured is alive and the death proceeds from claims of the insured's creditors as well as the beneficiary's creditors. The beneficiary may further be protected from claims of the beneficiary's creditors over and above this exemption through the spendthrift clause.

Proceeds of a life insurance policy made payable to an estate become a part of the insured's general estate, subject to the expense and delays of administration, in some instances to higher taxes, and to the claims of the insured's creditors. A Consent to Transfer from the inheritance tax authorities may be required before proceeds can be transferred to a named beneficiary. Life insurance proceeds payable to a named beneficiary are payable under contract right; the fact of death automatically makes such funds the property of the beneficiary. There is no probating, no delay in settlement, no publicity and no expense.

Assignment - An assignment is a transfer of all or a portion of the policyowners rights, title or interest in the insurance contract. Usually, the rights transferred are those rights to receive some or all of the policy benefits or values. To be binding on the insurer the assignment should be executed in writing and filed with an authorized representative of the insurer.

> Collateral assignment - is made to secure an indebtedness. The assignee is a creditor of the assignor and by the assignment receives only a stipulated amount not to exceed his/her interest as it may appear.
>
> Absolute assignment - is made to transfer all of the assignor's rights in the policy to the assignee. It conveys a complete transfer of ownership.

The **assignee** is the person who receives the policy or an interest in the policy by virtue of the assignment. The assignor is the person who makes the assignment and transfers the interest.

Insurance law generally provides that a life or disability policy may pass by transfer, will or succession, except for group life and disability policies and individual noncancellable loss of time policies, which may provide that benefits payable are not assignable.

OWNERSHIP & CONTROL

Ownership and Control provisions provide that the owner may exercise all rights under the policy during the lifetime of the insured, if the owner is a person other than the insured. It allows for a change in ownership, if the change is in writing and on file with the company. In addition to the policy provisions just presented, there are other provisions commonly used in many policies, with which a new licensee should be familiar.

AUTOMATIC PREMIUM LOANS

The Automatic Premium Loan is an optional provision and is usually requested by the insured. There are some insurer's that make it a standard provision and then the insured must request it be excluded. In either case; the provision is intended to prevent lapsing of the policy when that policy has loan values sufficient in amount to pay

the premium due. It usually provides that if premiums are not paid before the end of the grace period, the amounts of the premiums will be automatically charged against the loan value of the policy as a policy loan with interest. As long as there is enough loan value in the policy to meet the premium due, plus any accrued loan interest, the policy will not lapse.

AUTOMATIC PAYMENT BY DIVIDENDS

Automatic Payment of Premiums by Accumulated Dividends is an optional provision that states if the overdue premiums remain unpaid after the expiration of the grace period, and if at that time there are sufficient accumulated dividends, the necessary amount of such dividends will be automatically applied to the payment of the premiums.

CHANGE OF PLAN

The Change of Plan is a provision that appears in the permanent contracts of some companies guaranteeing the insured the right, on any anniversary, to exchange the contract for any higher premium policy written as of the same date of issue and for the same face amount and for no longer term, by payment of the required amount. Some companies which do not have this provision in their policies usually permit this kind of exchange by company practice.

WAR CLAUSE

A War Clause is a provision that states if the insured's death occurs under wartime or military service conditions spelled out in the clause, the company will be liable only for return of premiums or reserve. Generally, this provision is inserted only in policies issued during wartime. After a war emergency it has been the practice of companies to cancel all war clauses in their issued policies.

AVIATION CLAUSE

An Aviation Clause is a provision that provides that if the insured's death results from an aviation accident in which the insured was involved, other than as a fare-paying passenger on a regularly scheduled airline, the company will be liable only for a return of premiums paid. This clause is normally used when it has been indicated that the applicant for life insurance is subject to extraordinary aviation hazard. It is possible for the applicant subject to the extraordinary hazard to be covered for the hazard by paying an extra premium.

OPTIONAL POLICY FEATURES

Most life insurance policies issued today contain one or more optional features that give the insured more complete protection.

Disability Waiver of Premiums - in most companies, these provisions may be added to or included in life insurance policies upon application by the insured, subject to satisfactory evidence of insurability, and the payment of a modest additional premium. It stipulates that if the insured becomes totally disabled, premium payments will be waived during the period of disability. These provisions usually become inoperative at an age stipulated in the policy (such as 60 or 65 years) and usually, but not always, with a reduction of premium on the policy. However, if the disability is incurred prior to that age, the premiums may continue to be waived until the disability is no longer total or until the policy matures. The disability have an "elimination period" during which a total disability must continue before disability benefits are payable. Most policies now require an elimination period of six months with waiver of premium benefits retroactive to the start of the disability.

The waiver of premium provisions usually require that notice of claim must be given during the lifetime of the insured and during the continuance of the disability, except if it is not reasonably possible to give notice within such time, then notice must be given as soon as it is reasonably possible. Satisfactory proof of disability is usually required to be furnished from six months to one year after actual notice of disability, and the company's liability for benefits, retroactively, is usually limited to those proven within the time required of such proof. Proof of continuance of disability on demand by the company may be required as a condition of granting continued disability benefits, and the company retains the right to have the insured medically examined as often as it may

reasonably require, but not more often than once a year after the disability has lasted a specified period, usually two years, but sometimes only one year.

Some policies may presume that disability is total if the insured has suffered the loss of sight of both eyes (irrevocably), or loss of both hands, or of both feet, or of one hand and one foot. Some policies state "loss of use" is sufficient to prove total disability.

If and when the insured recovers, after having been considered as totally disabled, premium payments resume with the first due date subsequent to the date of recovery. Usually the amount of premiums waived will have no effect on the death or endowment benefits payable under the policy. Some policies, however, do contain an "installment disability" provision under which each installment payment reduces any proceeds later payable at death or maturity.

Some risks are generally excluded from coverage under the waiver of premium provisions. Disability arising from or caused by:

1) Self-inflicted injury, and military or naval service in time of war.
2) It is to be noted that there are in excess of 30 types of risks excluded from coverage under these provisions in policies issued by companies doing business in most states, and that the two stated are those most generally found.

Accidental Death Benefits - these provisions may be added to or included in life insurance policies upon application and the payment of a modest additional premium. In most cases, it provides for an additional payment equal to the face amount of the policy, when the insured dies within a specified period (usually 90 days) after, and as a result of an accident. At the age stipulated in the policy, usually 60, it becomes inoperative with a corresponding reduction of premiums on the policy. Some accidental death benefit provisions do not contain any such age limit for becoming inoperative.

Restrictions usually placed in accidental death benefits clauses relate to claims arising from suicide, self-inflicted injury, war service, aviation, participation in riot or insurrection.

Guaranteed Insurability Rider - is a supplementary benefit to a life insurance policy which has been offered by some companies for an additional premium. It gives the insured options of obtaining additional insurance on certain selected dates in the future, regardless of the then state of the insured's medical insurability. Upon exercising any such option, the new insurance is then issued at standard rates according to the attained age at the option date.

PREMIUMS

The premium is the amount specified in the policy as the charge for the insurance. In life insurance, premium calculations are made using the following four factors:

1) The "risk" factor which is determined by using the mortality rates at successive ages and the probabilities of survival. These probabilities are found in a mortality table which is a scientific compilation showing from a specified number of people at each age, the number on an average who will die each year.

2) The "interest" factor which is the anticipated earnings by the insurer from the investment of policy reserve funds.

3) The "loading" factor which is the anticipated expenses that the insurer will incur for issuing a contract. These expenses may include premium taxes, cost of licenses and fees, the expenses of acquisition, administration, operations and overhead. In some cases, an allowance for other contingencies such as policyowners dividends, are included.

4) The "duration" of premium payments (single premium, whole life, limited payments) and mode of premium payments (annual, semi-annual, quarterly, monthly or weekly).

The most common premium used is called a level premium. It is called "level premium" because the premium amount remains constant throughout the premium paying period. The premium does not increase after the policy has been issued, even though the insurance risk increases with advancing age when the chance of dying becomes greater.

No life insurer may discriminate, in availability of coverages or rates, on the basis of a person's race, color, religion, national origin or ancestry. No insurance application or investigation report used to determine insurability shall carry any identification of these factors. Further, no insurer may discriminate, in the availability of all lines of insurance, based upon a person's sex, marital status or sexual orientation, but rate discrimination based on these factors is permissible.

INFLATION-ADJUSTED LIFE INSURANCE COST INDEX

The Life Insurance Interest Adjusted Cost Comparison Index is a measure of the relative costs of similar plans of life insurance. A low index number represents a lower cost to the insured than a higher index number in the event a policy is surrendered at the end of a designated period. This index number must be presented to prospective purchasers of life insurance by the agent or insurer at the time a presentation is made showing or comparing the cost of life insurance over a period of years.

The Index provides one means of comparing the relative costs of two very similar policies sold by the same or different companies, but it does not consider the value of the services of an agent or company, the relative strength and reputation of the company, or small differences in the policy provisions.

SUBSTANDARD RATES

Substandard insurance is the term used to identify policies issued to persons who do not meet the standards for insurance at regular rates. Some factors which may make a risk less desirable than normal for its class are physical impairment or occupational hazards. When this is the case, a higher premium rate is charged because of the increased mortality hazard. Generally, there are four methods used to establish the extra premiums for such ratable hazards:

1) A flat additional charge; which may be permanent, or limited to a specified period of years. Sometimes the charges decrease annually.
2) Using the premium established for an age older than that which the insured has actually attained.
3) Using "class" or "special class" rates based upon extra percentage mortality tables which reflect the higher mortality rates for various physical impairments or occupations with increased hazards.
4) Restricting the type of policy to be issued. Generally term policies are not permitted, and only higher premium policies such as endowments or retirement income are issued.

TYPES OF LIFE INSURANCE

Life insurers will normally divide their underwriting operations into three departments, ordinary, industrial and group.

Ordinary Department

Ordinary Departments write the following types of policies: (1) whole life (also called ordinary life); (2) limited payment life; (3) universal life; (4) endowments; (5) term, and (6) annuities. On these policies, level premiums are paid annually, semiannually, quarterly or monthly. The amount of the insurance is usually $1,000 or more, and the amount of insurance measures the amount of the premium.

1) Ordinary whole life insurance on the level premium basis is the lowest premium form of permanent lifetime coverage that can be purchased. Level premiums are payable throughout the entire lifetime of the insured and the insurance amount becomes payable upon the death of the insured. Nonforfeiture values, including cash and loan values, usually become available after premiums have been paid for two or three years under this form of insurance coverage.

2) Limited payment life insurance is also a form of lifetime coverage. Unlike ordinary whole life, level premiums are payable only for a limited period after which the insurance becomes fully paid. The premium paying period may be for a specified number of years, such as 10, 20 or 30 years, or to an attained age specified in the policy such as to age 80 or 85. Premiums vary according to duration of payment. Thus, the shorter the premium paying period the higher the annual premium. The insurance amount becomes payable only upon the death of the insured. Nonforfeiture values, including cash and loan values, are also available under this form of insurance coverage.

3) Universal Life: The term "Universal Life" is used to describe a product which is comprised of two parts; pure insurance protection and a cash value account. The premium payments, which may be made on a flexible basis, are credited to the fund which earns a current rate of interest. The rate of interest may be adjusted to reflect policy loan utilization. The cost of the pure insurance is deducted from the fund, thus the policy will remain in force as long as there is sufficient money in the cash value account to meet the monthly expenses. The death benefit may be either a level amount of insurance, or a level amount plus the value of the fund. The tax implications of a Universal Life policy are both important and complex, and must be fully understood by agents selling this type of product.

4) Endowment insurance provides life insurance protection only for a limited number of years, commonly referred to as the "endowment period." However, it also involves a savings feature which results in the maturing of the policy for its face value upon reaching the end of the endowment period during the lifetime of the insured. Thus the face amount is payable either upon death, if within the endowment period, or upon survival of the insured at the end of the endowment period. The term of endowment may be any specified number of years, such as 20-year endowment, or an endowment at a specified age, such as an endowment at age 65. Because provision is made for payment of the face amount either at time of death or upon survival by the insured of the endowment term, the level premium under this type of policy is higher than under the above forms for equivalent payment periods and ages at issue. Nonforfeiture values, including cash and loan values are available and are usually greater than whole life or limited life policies for equivalent policy amounts.

5) Term Insurance is sometimes referred to as "temporary insurance" although this author believes it has a definite place in the financial planning cycle. It is customarily purchased to provide insurance protection for a limited number of years--5 to 20 years, or even longer. The premiums are low and are so calculated as to be just sufficient to defray the cost of protection for the period insured. The insurance amount is payable only if the death of the insured occurs during the term period and while the policy is in force. Nonforfeiture values, if any, are very small. The insurance expires at the end of the term period, but if the policy so provides, it may be renewed for another term period; provided, however, that premiums are paid at the then-attained age of the insured. After repeated renewals, premiums become prohibitive and for that reason term policies ordinarily do not allow the privilege of renewal beyond a certain age (usually age 65). Most term policies are convertible to permanent life insurance, without evidence of insurability, either at the original age or the attained age.

   *Note: In recent years, many companies have been providing **"re-entry" policy** options for present owners of term insurance. "Re-entry term" policies permit the insured to renew policies at the initial rate for the insured's presently attained age if the insured provides evidence of insurability, i.e., another medical exam or questionnaire, at the time of "re-entry".*

6) Annuity is the right to give or receive a series of payments of an amount of money, or a contract that provides an income for a specified period of time, such as a number of years or for life. An annuity is a means of liquidating a given amount of principal over the lifetime of the annuitant. It is a method whereby a person can receive payments of both principal and interest from his/her investment without the danger of outliving his/her capital.

Industrial Department

An Industrial Department is where "intermediate insurance" is written. On these policies, level premiums are paid either weekly or monthly. The amount of the premium, usually 10 cents or more a week, measures the amount of insurance, which is generally less than $1,000, although some companies issue "intermediate" contracts of

higher face amounts. The cost to the insured is necessarily higher in relation to amounts of coverage provided in order to defray the higher costs of handling premium collections at frequent intervals and the smaller unit amounts, and further, because ordinarily there is less strict medical selection and therefore a higher rate of mortality in the case of industrial insurance than is true in the case of ordinary insurance.

Insurance codes define industrial life insurance as life insurance with an aggregate face amount sold to any one insured and in force at any one time in an amount not exceeding ten thousand dollars ($10,000). Premiums are payable at least monthly and collected in person, not by mail, with a written receipt delivered to the insured.

Industrial insurance is usually limited to whole life, limited pay life and endowment plans. Term insurance is not written. Basic features of an industrial policy are similar to those of the ordinary department policies, except some provisions are different.

Facility of payment clause - if the beneficiary named in the policy does not submit a claim within 30 or 60 days after the insured's death, or if the beneficiary predeceases the insured or is legally incompetent, the company may make payment to the insured's estate or to any relative of the insured who appears to the company to be equitably entitled to such payment.

Assignments - an industrial policy, if assignable at all, is assignable only to a bank as collateral for a loan.

Loans - there is no provision for policy loans.

Accidental death and dismemberment - double indemnity and lump sum benefits for loss of sight, or dismemberment is usually included in industrial contracts at no extra cost.

Lump sum payments - there is usually no provision for settlement options, because of the small amount of insurance involved.

Application - in industrial insurance, the application is not usually made part of the policy, as in ordinary insurance.

Suicide clause - industrial contracts generally contain no suicide clauses.

Group department, in which are written employee groups, labor union, National Guard, association and credit union groups, agent-principal groups, trustee groups, and groups including borrowers from financial institutions. The premiums are usually collected from one central source, most frequently the master policyholder. The policy usually used is similar to one-year renewable term insurance. Many companies, however, will issue permanent life insurance on a group basis.

SPECIAL POLICY DISCLOSURES

Credit Life

Every application and policy of credit life must have a statement in bold capital letters indicating that pre-existing health conditions of the applicant may render the coverage void.

Term Life Directed to Persons 55 Years & Older

Advertising for term life insurance directed to individuals 55 years and older must

1) Clearly and prominently distinguish basic life insurance benefits from supplemental benefits such as accidental death benefits
2) Prominantly disclose any limitations, exceptions or reductions affecting each benefit
3) Prominantly disclose any condition affecting continued insurability of the insured. Specify coverage that terminates at a particular age
4) Disclose any change in benefits resulting from the aging of the insured
5) Disclose any change in premium resulting from the aging of the insured as well as any right he or she has to

modify premiums

6) Television and radio ads (spoken text) should contain the statement "policy benefits and limitations should be carefully examined prior to purchase"

Annuity & Life Insurance Sales to Senior Citizens

By many insurance codes, an individual life insurance policy or annuity contract delivered or issued to a senior citizen must include a printed statement advising the policy owner's right to cancel the policy within 30 days by returning or mailing in to the insurer or agent. Returning the policy during this period has the effect of voiding the policy from the beginning. All premiums and fees must be returned to the insured within 30 days.

Additionally, all policies shall have the following notice either printed on the cover or policy jacket in 12-point bold print:

IMPORTANT

YOU HAVE PURCHASED A LIFE INSURANCE POLICY OR ANNUITY CONTRACT. CAREFULLY REVIEW IT FOR LIMITATIONS.

THIS POLICY MAY BE RETURNED WITHIN 30 DAYS FROM THE DATE YOU RECEIVED IT FOR A FULL REFUND BY RETURNING IT TO THE INSURANCE COMPANY OR AGENT WHO SOLD YOU THE POLICY. AFTER 30 DAYS, CANCELLATION MAY RESULT IN A SUBSTANTIAL PENALTY KNOWN AS A SURRENDER CHARGE.

Policies and annuities that contain a surrender charge period shall also disclose the surrender period and all associated penalties in 12-point bold print on the cover sheet of the policy or in the same print indicate the location of all surrender penalties.

Life Insurance and Annuity Illustrations for Senior Citizens

Illustrations use to sell annuity contracts or life insurance to senior citizens shall disclose in 12-point bold print or by bright high lighter pen the following statement:

THIS IS AN ILLUSTRATION ONLY. AN ILLUSTRATION IS NOT INTENDED TO PREDICT ACTUAL PERFORMANCE. INTEREST RATES, DIVIDENDS, OR VALUES THAT ARE SET FORTH IN THE ILLUSTRATION ARE NOT GUARANTEED, EXCEPT FOR THOSE ITEMS CLEARLY LABELED AS GUARANTEED.

Variable Life & Variable Annuity Contracts for Senior Citizens

Every variable life or variable annuity contract issued or delivered to a senior citizen must have the following notice printed in 12-point bold print:

IMPORTANT

YOU HAVE PURCHASED A VARIABLE ANNUITY CONTRACT (VARIABLE LIFE INSURANCE CONTRACT). CAREFULLY REVIEW IT FOR LIMITATIONS.

THIS POLICY MAY BE RETURNED WITHIN 30 DAYS FROM THE DATE YOU RECEIVED IT FOR A REFUND OF THE POLICY'S ACCOUNT VALUE ON THE DAY THE POLICY IS RECEIVED BY THE INSURANCE COMPANY OR AGENT WHO SOLD YOU THIS POLICY. A RETURN OF THE POLICY AFTER 30 DAYS MAY RESULT IN A SUBSTANTIAL PENALTY KNOWN AS A SURRENDER CHARGE.

GROUP LIFE INSURANCE

A life insurer may issue life, disability, term, and endowment insurance on the group plan, with or without

annuities and with premium rates less than the usual rates for such insurance.

The principal forms of group life insurance are employee-employer, association, trade association, borrower-purchaser, credit union-borrower, trustee and agent-principal groups.

Group life insurance policies are sometimes referred to as "contributory" or "noncontributory." If the insured members contribute part or all of the cost of the insurance the individual obtains under the policy, it is a "contributory" policy. The term "noncontributory" implies that the entire premium for the group policy is paid by the master policyholder, and no contributions specifically identifiable for insurance are required from the individuals.

In group life insurance the term "employees" includes officers, managers, and employees of subsidiary or affiliated corporations, partners and employees of affiliated individuals and firms. Employee-employer life insurance policies may extend the benefits to proprietors or partners of the policyholder who actively engage in business.

Employee-Employer Policies

An employee-employer life insurance policy must conform to the following requirements: (1) cover when issued not less than 10 public or private employees; (2) be issued to the employer and the premium paid either by the employer or by the employer and the employees jointly; (3) insure 75 percent of all the employees or of any class or classes determined by conditions pertaining to employment. If the policy is intended to insure several classes it may insure any class when 75 percent of the class is covered and be extended to the other classes as 75 percent of the class express a desire to be covered; (4) provide a plan which precludes individual selection as to the amount of insurance; (5) be for the benefit of persons other than the employer; (6) where the premium is paid jointly and the benefits of the policy are offered to all eligible employees the policy may be made effective only when not less than 75 percent of the employees are covered. The policy terminates after issue if (1) the number of employees insured falls below 10 lives or 75 percent of the number of employees eligible, and (2) the employees' contributions, if the premiums for the insurance are on a renewable term insurance basis, exceed $1 per month per $1,000 of insurance coverage plus an additional charge for hazardous occupations.

Trade Association Group Policies

A trade association group policy is a policy issued to a trustee of a fund established by the employer members of a trade association and maintained by contributions of such members for the sole benefit of their employees. The trade association (1) must have been formed for purposes other than obtaining insurance and must have been in existence five years, or (2) must be a statewide association having over 500 members, which has been in existence for 10 years or longer and consists of employer members engaged in any one or more of the manufacturing, fabricating, or processing industries. The policy must cover at least 75 percent of the eligible employees of at least 50 percent of the total employer members of the trade association, unless the number of lives insured at date of issue exceeds 600, in which event the policy must cover 75 percent of the eligible employees of at least 25 percent of the employer members of the trade association. In determining the total number of employer members those whose employees already are covered by group life insurance may be excluded. When issued, the policy must cover 100 lives.

Trustee Group Policies

A trustee group policy is a group life policy issued to the trustees of a fund established by:

1) One employer or two or more employers in the same industry, or by association of employers in the same industry, or
2) One or more labor unions, or
3) One or more employers and one or more labor unions or an association of employers and one or more labor unions; under the following conditions:

    (A) The trustee is the policyholder and the policy is for the benefit of persons other than the employers or unions.

(B) All employees of the employers, and all union members, or all of any class or classes determined by conditions pertaining to their employment, or to membership in the unions, or both, are eligible for insurance. If the policy is on a noncontributory plan, coverage must extend to all eligible persons. Where there is a contributory plan in effect, insurance must extend to each contributory class, and, if contributions are not required from one or more classes, the policy must insure all persons from whom no contributions are required. The policy may exclude those not presenting satisfactory evidence of insurability. The policy may provide for including of retired employees.

(C) Individual proprietors, partners, and corporate directors may be covered if they are bona fide employees. The trustees or their employees, or both, may be covered if their duties are principally connected with the trusteeship.

(D) The trustee pays the premium from funds contributed by the employers or unions or both, or partly from such funds and partly from funds contributed by either all insured persons or one or more classes thereof. No policy may be issued for which the entire premium is derived from contributions from the insured persons specifically for the insurance.

(e) 75 percent of the individuals in the eligible contributory classes must participate initially.

(f) At date of issue the policy must cover at least 50 persons.

(g) Individual selection of amount of insurance is not permitted.

(h) The insurance may be issued with or without medical examination.

The word "industry" shall include licensed professions, such as medicine, dentistry, pharmacy, law and accountancy.

An association group policy is a group life policy covering when issued not less than 25 members of:

1) A labor union;
2) The National Guard;
3) An association of government or public employees;
4) A credit union (whether borrowers therefrom or not);
5) An association of private employees of a common employer formed for purposes other than insurance and in existence at least two years whose membership includes 75 percent of those eligible for membership in the association;

With the following conditions:

1) The union, credit union, or association is the policyholder.
2) The premiums are payable by the union, credit union, or association or jointly with the members or by the members alone.
3) The policy must insure only members of such union or unions or members of such credit union or association.
4) There can be no individual selection of the amounts of insurance.
5) The beneficiary must be someone other than the union, credit union, or association, or its officials. When written the policy must cover 75 percent of a particular class determined by conditions pertaining to employment.
6) The policy may be issued to classes within a group.
7) The policy may not be issued to an association of the employees of a common employer unless the employer agrees in writing to deduct the premium from wages or salaries.

Group life policies for employee-employer, trustee groups, trade associations, association groups and agent-principal groups may, if 75 percent of the insured's elect, be extended to insure dependents on a plan which precludes individual selection as to amount, which amount shall not exceed 50 percent of the insurance on the life of the insured employee or $5,000, whichever is less; provided that the amount for a dependent at death under age six months shall not exceed $500.

Borrower-Purchaser Group Life

Borrower-purchaser group life insurance covers:

1) Borrowers from one financial institution who are under agreement to repay sums borrowed; or
2) Purchasers of merchandise or other property (exclusive of securities, investment certificates and bank deposits) under an agreement to pay the balance of the purchase price.

The following conditions apply to both groups:

1) The group must have at least 100 new entrants yearly.
2) The amount of insurance does not exceed the balance due to the institution or vendor and in any event does not exceed $50,000 on any one life, or $100,000 for agricultural loans.
3) An installment payment plan may not exceed 32 years. Agricultural and horticultural loans are further restricted. The latter must provide for repayment within 18 months, either in one sum or in irregular installments.
4) The policy is issued to and payable to the institution, vendor or creditor-transferee, and the premiums are paid by or through the institution, vendor or creditor-transferee.
5) Individual certificates are not required to be issued to the members of a borrower or purchaser group.

Creditor Union-Borrower Group Life

Credit union-borrower group life insurance is issued to a credit union covering the lives of every eligible member of the group, or persons who are or become borrowers from the credit union; under the following conditions:

1) The group must have at least 50 borrowers yearly.
2) The amount of insurance may not exceed the balance of the indebtedness and may not exceed $50,000 on any one life.
3) The loan is repaid in installments over a period not exceeding 30 years.
4) The policy is applied for, issued to, and payable to the credit union. The premiums may be paid by the credit union, the borrower or jointly by the credit union and the borrower. Individual certificates are not required to be issued to the members of a credit union group.

Agent-Principal Group Life

An agent-principal group life insurance policy at issuance must cover not less than 10 agents; under these conditions:

1) The policy is issued to the agent's principal, and the agent must be under contract to render personal services to his or her principal on a commission or other ascertainable compensation basis.
2) The premium for the policy may be paid by the principal or by the principal and the agents jointly.
3) The policy must insure either all of the agents or all of the agents of any class or classes determined by conditions pertaining to services to be rendered. If the policy insures several classes it may be issued to any class of which 75 percent of the class are covered.
4) The insurance must be upon a plan which will preclude individual selection as to amount.
5) The principal may not be the beneficiary.
6) When the policy is on a contributory basis and the benefits of the policy are offered to all eligible agents, the policy must insure at date of issue not less than 75 percent of such agents.
7) The policy terminates if subsequent to issue (1) the number of agents falls below 10 lives or 75 percent of the number eligible, and (2) the contributions of the agents, if the premiums for the insurance are on a renewable term insurance basis, exceed $1 per month per $1,000 of insurance coverage plus additional amounts charged to cover hazardous occupations.

Group Life Terms & Conditions

In group life insurance, the term "employer" includes the association, union or credit union referred to in the association policies, and the institution, vendor, credit union, or creditor referred to in the borrower and purchaser and the credit union-borrower policies, and the trustees referred to in the trustee group policies, and the principal in agent-principal group policies; and the term "employee" includes the members of a union, credit union, or association of employees and the borrowers or purchasers from the institution, credit union, vendor, or creditor, the employees of the trustee, and the agents.

All group life policy forms must be filed with the Insurance commissioner and approved by him prior to issue.

Every group life policy must provide that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any employee insured under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such employee's lifetime nor unless it is contained in a written application signed by the employee.

All group life policies may exclude or reduce amounts payable when loss is caused by:

1) War or any act of war;
2) Military or naval service; or
3) Aviation.

All group life policies must contain provisions that:

1) The policy and the application of the employer and the individual applications, if any, of the employees, constitute the entire contract.
2) All statements made by the employer or the employees, in the absence of fraud, are representations and not warranties.
3) Statements will not be used in defense to a claim unless contained in a written application.

Each policy shall contain a provision for the equitable adjustment of the premium or amount of insurance in the event of misstatement of age.

The policy must provide for issuance of individual certificates delivered to the employer for delivery to insured employees. (Certain types of credit life insurance are exempted from this requirement.) The certificate must set forth:

1) A statement of the insurance and to whom payable
2) An employee conversion option to elect for the employee or spouse, if insured, an individual life policy except term, in an amount not exceeding the group coverage, exercisable, without proof of insurability, for 31 days following termination of employment.
3) That an employee or spouse who dies during the 31-day period after termination of employment and before making election to convert to individual coverage will have paid to the person entitled thereto, as a claim under the group policy, the amount of insurance to which the employee or spouse is entitled to convert to as an individual policy.
4) An employee insured under a group life insurance policy, who was not, at least 15 days before the end of the conversion period, given notice of the right of conversion to an individual policy, shall have 25 days after notice in which to convert. However, such additional period cannot extend more than 60 days beyond the end of the conversion period in the policy.
5) A group life insurance policy may contain provisions defining the extent to which the employer may act as agent of the employee, or of the insurer.

Every group policy must contain a provision for the addition of new eligible employees. If the policy is contributory it may provide that such employees must apply within a given time or be required to furnish evidence of insurability.

Any group life policy may contain:

1) Any provisions required by the law of the home state of such insurer;
2) When issued in another state or country by a domestic insurer any provision required by the laws of such state or country;
3) The subject matter in a form more favorable to the employer or employees than those provisions stated is permissible.

In every group life policy issued by an admitted insurer the "employer" is the policyholder for all purposes within the meaning of the Insurance Code and when policyholders have voting rights is entitled to one vote.

Except in borrower and purchaser groups and credit union-borrower groups the proceeds of group life insurance are not liable for debts of the employee or beneficiary.

Continuation of Group Policies During Labor Disputes

In anticipation of labor disputes, all group policies must comply with the following:

1) Every group life insurance policy where the employer pays all or a part of the premium under the terms of the collective bargaining agreement must contain a provision that the individual employees may pay the premiums and continue their coverage during the periods of work stoppages due to labor disputes.
2) Methods of determining the amount of each employee's contribution (premium) in such cases are provided by law.
3) The insurance companies are given certain rights, such as:

    A) To require that contributions of the employees must be made to the company within prescribed time limits if coverage is to continue as to each such employee.

    B) To increase each individual premium rate 20 percent (or higher if approved by the Insurance Commissioner) to provide for increased costs.

    C) The company has the continued right to increase premium rates despite cessation of work if it had the right to do so had the work stoppage not occurred.

    D) The company is not required to continue loss-of-time disability payments.

    E) The company is not required to continue any coverage:

    Beyond the time that 75 percent or less of the employees continue such coverage.

    Beyond the time that it takes full-time employment with another employer.

    Beyond six months after cessation of work.

    F) Nothing in this law affects unemployment compensation disability insurance (U.C.D.).

Discontinuance of Group Life Insurance

Certain group life insurance policies must provide extended benefits for insured’s who are totally disabled at the date coverage would otherwise terminate because of termination of the master policy or because of termination of participation by an entire employer unit under a master policy insuring a number of employer units.

Life insurance coverages not accompanied by related disability benefits (such as waiver of premium) must provide a disabled employee or member with a right to convert to individual coverage. Life insurance coverage’s accompanied by related disability benefits must be continued until termination of the disability benefit by its own terms, at which time a right to convert must be provided. These rights of conversion and extension need be provided only to the extent that similar coverage is not provided by a replacement plan.

Transfers

In group life insurance the benefits may be made nonassignable by a policy provision to that effect. Otherwise a policy of life insurance may pass by transfer, will, or succession whether or not the transferee has an insurable interest. A policy of life insurance may be validly transferred without notice to the company unless such notice is expressly required by the policy.

SUMMARY

In life insurance the only measure of liability and damage is the amount payable as provided in the policy to the person entitled to its benefits.

Life insurance differs from all other forms of insurance in that it primarily grants protection against an event which is certain-namely, death. The uncertain element is the time at which the death will occur. In other forms of insurance the event insured against may or may not happen and in the majority of policies, usually does not occur.

Benefits paid by life insurance companies are payable not only upon the occurrence of death of the insured but are payable under other circumstances as well. Annuities and endowment policies are payable upon the contingency of the insured's being alive at a certain time or during a certain period. Life insurance policies may provide benefits for disability in the forms of waiver of premiums and/or monthly income payments to the insured. All permanent forms of life insurance policies provide stipulated cash values which may be withdrawn by the policyowner in a lump sum or in installments if he or she wishes. In recent years, most life insurance companies have paid more money to living policyowners as "living benefits" than to beneficiaries of deceased insured's.

There are two parties to a life insurance contract--the insurer, which agrees to accept premiums and disburse moneys upon the happening of the contingency, and the insured upon whose life the contract is based. The beneficiary is not a party to and has no rights under the contract until it has matured by death of the insured or by endowment, except when the beneficiary is named irrevocably. In the latter instance, the insured has not reserved the right to change beneficiaries and the irrevocably-designated beneficiary possesses joint ownership rights with the insured.

If the insured assigns the contract absolutely--in form and substance--the assignee, who may or may not be the beneficiary, succeeds to all rights of the insured. Some policy forms contain an ownership clause which may designate the insured or a person other than the insured as owner of the policy. Such ownership clauses may be used as a means of changing policy ownership instead of using an absolute assignment for this purpose. In all cases, however, the life insurance policy is a two-party contract although one of the parties--the insured and irrevocable beneficiary--is a joint ownership arrangement.

Many life insurers avoid the use of irrevocable-beneficiary designations to eliminate misunderstanding as to the beneficiary's interest. These insurers use instead provisions such as "Limitation of Rights" provisions so as to define precisely which of the policyowners' rights can be exercised only with the consent of the beneficiaries.

In general, the death rate increases with age. To pay the exact cost of insurance at each age would result in the payment of prohibitive costs at the older ages. For this reason most forms of life insurance are written on a continuous form known as level premium insurance. In the early years, the insured's level premium is greater than the amount needed to pay death benefits for that age group. These extra funds are invested by the insurer. In later years, these funds and their earnings are used to pay the difference between the premium, which remains level, and the rising cost of insurance caused by increased death rates. Life insurers, unlike property and liability insurers, have accumulated substantial reserve liabilities as offsets to these extra funds which are safely invested for the protection of their policyowners and beneficiaries. Since this is an operation which, insofar as its scope at least is concerned, is uniquely different from the operations of other types of insurance carriers, it is usual for life insurance to be transacted by companies engaged in that business only or engaged in it primarily and in accident and health secondarily.

DISABILITY INSURANCE

Disability policies have a much broader scope than other lines of insurance. Generally, before a person can have a property insurance need, that person must own or have a monetary interest in the property or business. However, virtually everyone has a need for one or more types of disability insurance.

In most states, the term “disability insurance” refers to many types of coverage, including:

1) accident and health
2) accident and sickness
3) medical, hospital, surgical expenses
4) disability & credit disability plans

Policies are distinguished between those covering ONLY disability, to those covering disability AND medical, hospital, surgical benefits; to those policies covering ONLY medical, surgical and hospital expenses. The latter is defined as a “health benefit plan”.

Disability insurance insures against losses which result from injury to or sickness of an insured person. It does not include insurance against the liability of an insured person for injuries to third persons.

LOSSES COVERED BY DISABILITY INSURANCE

The principal types of losses insured against by disability insurance are:

1) Expenses incurred for hospital confinement and for medical and surgical treatment ("hospital, medical and surgical");
2) Fixed daily benefits for hospital confinement ("hospital indemnity");
3) Loss-of-income resulting from injury or sickness ("loss-of-time");
4) Accidental death and dismemberment;
5) Loan payments becoming due while disabled ("credit disability" and "mortgage disability");
6) Office or business expenses which continue during the disability of a professional or proprietor, such as office rent, etc. ("business overhead expense").

Disability insurance is also used for special business and investment purposes, such as funding "buy-out" agreements when a partner in a partnership or a stockholder in a close corporation becomes permanently disabled or to provide funding for a continuing investment program during the disability of the investor.

TYPES OF DISABILITY COVERAGE

Insurance regulations, which establish Standard Supplemental Disclosure Forms which must be used in soliciting disability insurance, classify disability coverages into the following major categories:

"Basic Hospital Expense Coverage" provides benefits for expenses incurred for daily hospital room and board and usually covers miscellaneous hospital services incurred as a result of covered accident or sickness. Benefits may be subject to a deductible amount and to a co-payment requirement.

"Basic Medical--Surgical Expense Coverage" provides benefits for expenses incurred for surgical, anesthesia and in-hospital medical services incurred as a result of covered accident or sickness. Benefits may be subject to a deductible amount and to a co-payment requirement.

“Basic Hospital and Medical--Surgical Coverage" provides benefits for expenses incurred for daily hospital room and board, miscellaneous hospital services, surgical, anesthesia and in-hospital medical services incurred as a result of covered accident or sickness. Benefits may be subject to a deductible amount and to a co-payment requirement.

"Hospital Confinement Indemnity Coverage" provides a stipulated daily benefit for hospital confinement as a result of covered accident or sickness. Other benefits, such as accidental death and dismemberment coverage, are often provided. Benefits may be subject to elimination periods.

"Major Medical Expense Coverage" provides benefits for major hospital, medical and surgical expenses incurred as a result of covered accident or sickness. Benefits are usually provided for daily hospital room and

board, miscellaneous hospital services, surgical and anesthesia services, in hospital medical services and prosthetic appliances, among other expenses. The maximum benefit for covered charges usually exceeds $10,000. Benefits are subject to substantial fixed or variable deductibles and may be subject to a co-payment requirement. Such coverage is often designed to be supplemental to "Basic Hospital and Medical-Surgical Coverage".

"Comprehensive Major Medical Expense Coverage" provides those benefits enumerated in the preceding paragraph, except that coverage is not designed to supplement other coverage and is usually subject only to modest fixed deductible amounts. Benefits are usually subject to a co-payment requirement.

"Disability Income Protection Coverage" provides benefits on account of the insured's inability, as a result of covered accident or sickness, to perform certain activities as defined in the policy. If the insured is employed for wage or profit, these activities are usually defined in terms of the insured's occupation or any occupation for which the insured is or becomes qualified by reason of education, training or experience. Where the insured is not employed for wage or profit, these activities are usually defined in terms of activities of a person of like age or sex. Benefits may be designed to replace lost income ("loss-of-time"), to make payments on loans ("credit"), or to pay expenses of the insured's office or business which continue during the insured's disability ("business overhead expense").

"Accident Only Coverage" provides any one, or a combination, of the foregoing types of coverage for losses resulting only from covered accidents. These policies usually provide an accidental death and dismemberment benefit in conjunction with loss-of-time or hospital and medical-surgical benefits. The accidental death and dismemberment benefit payable will sometimes vary depending upon the type of accident.

"Specified Disease Coverage" usually provides hospital and medical-surgical benefits for losses resulting only from the disease or diseases specified in the policy. Such benefits are usually designed to supplement other hospital and medical-surgical coverages which the insured has. The most common of such policies provide supplemental benefits for the treatment of cancer.

"Specified Accident Coverage" provides the same types of benefits as "Accident Only Coverage", except that coverage is limited to one or more types of accidents specified in the policy. The most common such policies provide accidental death and dismemberment benefits for losses resulting from common carrier (principally aircraft) accidents. Many policies sold in conjunction with newspaper and magazine subscriptions combine coverages for specific diseases and specific accidents.

"Medicare Supplement Coverage" provides benefits to supplement the coverage provided under either or both parts of Medicare. This coverage is further classified as "In-Hospital," "In-and-Out-of-Hospital" and "Catastrophic".

DISABILITY INSURANCE DISCLOSURES

The Health Insurance Disclosure Act of 1974 requires that a Standard Supplemental Disclosure Form ("Outline of Coverage") be provided to the prospective insured or group master policyholder whenever a specific disability insurance policy is solicited. (The Act establishes slightly different technical requirements for individual and group insurance policies.) The outline of Coverage summarizes the important provisions of the solicited policy in six paragraphs with the following captions:

1) Read Your Policy Carefully. This paragraph warns the insured that the outline is only a summary of the policy and that the policy is the entire contract and should be read carefully.
2) The second paragraph is captioned with the name of one of the types of coverages. This paragraph describes the benefits usually provided by the type of coverage being offered. However, the coverage being summarized may provide more or fewer benefits than those described in this paragraph. This paragraph may be omitted at the insurer's option.
3) Benefits of This Policy.
4) Exceptions, Reductions and Limitations of This Policy.
5) Renewability of This Policy.
6) Premium for This Policy.

The Outlines of Coverage are prepared by the insurer and all companies must follow the same format, which is prescribed by the Commissioner's regulations. However, the producer is responsible for the proper delivery of Outlines of Coverage when personally soliciting policies. Outlines of Coverage are also required in advertisements which contain applications for insurance.

TYPES OF DISABILITY POLICIES

"**Blanket policies**" are issued to master policyholders to provide benefits for members of eligible groups under circumstances specified in the Insurance Code.

"**Group policies**" are issued to master policyholders to provide benefits for members of eligible groups defined in the Insurance Code. Group members must be provided with individual "certificates of insurance" describing the major features of the master policy.

"**Individual policies**" are issued to individuals or heads of households to provide benefits for them and/or their dependents.

Members of groups covered under "blanket" and "group" disability policies have no direct contractual relationship with the insurer. Holders of individual policies contract directly with the insurer.

Except for credit disability policies, there are no standardized disability insurance policies established by law or recommended by the disability insurance industry. However, most disability policies are required to contain the Compulsory Uniform Provisions and, in some cases, may be required to contain one or more Optional Uniform Provisions. These Provisions are set forth in the Insurance Code and in the Regulations of the Insurance Commissioner. Except in the case of credit disability insurance, solicitations for disability policies must include standard supplemental disclosure forms. These forms are "standard" in that the information required to be disclosed and the format of that disclosure are Established by the Commissioner’s regulations, but most of the text used in the forms is drafted by the insurers.

INDIVIDUAL DISABILITY INSURANCE

“Individual disability” insurance policies may be issued under the following circumstances:

1) to individual persons.
2) to heads of households providing benefits for themselves and their dependents ("family" policies).
3) to employees of a common employer or to members of a common association ("selected group" or "franchise" policies).
4) to individuals or heads of household no longer eligible for group insurance coverage ("group conversion" policies).

The following types of disability benefits, when included in or attached to life insurance policies, are exempt from most of the Insurance Code Sections and Commissioner's Regulations applicable to individual disability policies:

1) Additional benefits for accidental death or dismemberment;
2) Waiver of premium benefits;
3) Loss of time benefits subject to elimination periods of at least 90 days.

Any other disability benefits are subject to the same requirements as if they were included in an individual disability policy.

Regardless of the coverage provided, all individual disability policies must comply with technical requirements relating to format and basic rules of administration. (Blanket and group disability policies are also subject to most of these requirements.) The more important of these requirements are summarized below:

Policy Format: An individual disability policy must:

(A) state the entire premium and other considerations for its issue;
(B) state the time when coverage commences and terminates;
(C) comply with requirements relating to type size, form numbers, location of exceptions, limitations & reductions, and references to outside documents;
(D) contain no reduction on account of age which, based upon the individual's age, is effective at issue.

Administrative Provisions: The following are the major provisions found in the individual disability policies. Group or blanket policies contain similar types of provisions plus additional provisions relating to eligibility, premium computation, etc., unique to such policies.

The "schedule" lists the names of the person or persons insured, the effective date of coverage, the premium and the policy serial number. Where benefits are variable at the option of the insured, the schedule usually details the benefit amounts, benefit periods and elimination periods. Special provisions applicable only to the individual insured, such as waiver of coverage for specified medical conditions, are sometimes printed on the schedule.

The "insuring clause" sets forth the formal agreement of the company to insure the insured. This clause often contains basic limitations of coverage, such as exclusion of occupational injury.

The "renewal provision" sets forth the terms upon which the insured may renew the policy. This provision will also set forth the insurer's right to terminate coverage, if any. Any right the insurer has to change premium rates should also be disclosed in this provision.

The "benefit provisions" set forth in detail the benefits provided by the policy.

The "exceptions. reductions and limitations provision" sets forth those losses which, although within the coverage defined in the insuring clause and/or benefit provisions, are still excluded from coverage. Exceptions, reductions and limitations may alternatively be stated in the benefit provisions to which they apply.

The "eligibility and termination provisions" are found in family policies and set forth the provisions under which coverage on the insured's spouse and dependents commences and terminates.

Uniform provisions: All disability policies must include the "compulsory uniform provisions" and may include one or more "optional uniform provisions". "Compulsory Uniform Provisions" are usually repeated verbatim in the policy, but that may be modified with the approval of the Insurance Commissioner. Policies issued by mutual or reciprocal insurers usually contain additional provisions relating to the policyholders voting rights. Both types of uniform provisions are discussed below.

Mandatory Policy Provisions

Entire Contract

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed and attached to the policy. No agent has authority to change this policy or to waive any of its provisions.

The application is often attached to and made a part of the policy. If the application is not so attached, the insured shall not be bound by any statement made in the application.

Incontestable Clauses

Policies other than noncancellable policies shall use Form A. Noncancellable policies shall use either Form A or Form B. In Form B the clause in parentheses in paragraph (a) may be omitted at the insurer's option. Paragraph (a) in Form A shall not so be construed as to affect any legal requirement for avoidance of a policy or denial of a claim during the initial three-year period in the event of misstatement with respect to age or occupation or other insurance.

Form A: "Time Limit on Certain Defenses"

(a) After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three-year period.

"(b) No claim for loss incurred or disability (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

Form B Incontestable:

(a) After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

The Uniform Time Limit on Certain Defenses and Incontestable provisions are divided into two parts: Part (a) relates to misstatements in the application. It prevents the use of such misstatements, except fraudulent misstatements, after three years from the date of issue to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period. It does not limit the application of the optional uniform provisions relating to change of occupation, misstatement of age, other insurance with this insurer, or insurance with other insurers, insofar as misstatement in respect to age, occupation, or other insurance are concerned. Part (b) relates to disease or physical condition which existed prior to the effective date of the coverage; it does not concern statements in the application, and prevents introduction of the existence of any disease or physical condition prior to the effective date of the coverage to reduce or deny a claim for loss incurred or disability commencing after three years from the date of issue of the policy, unless the condition is specifically excluded from coverage by name or specific description.

In a noncancellable or a guaranteed renewable policy it is permissible to use the Time Limit on Certain Defenses provision or the uniform provision captioned Incontestable.

Grace Periods:

Form A shall be used in a policy in which the insurer does not reserve the right to refuse any renewal. Form B shall be used in a policy in which an insurer reserves the right to refuse any renewal. The clause in parentheses may only be added if the policy contains a cancellation provision. In the blank in each such form shall be inserted a number; not less than '7' for weekly premium policies, '10' for monthly premium policies, and '31' for all other policies.

Form A

"Grace Period: a grace period of ( ) will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof)."

Form B

"Grace Period: Except, in the event that not less than five days prior to the premium due date the insurer has delivered to the insured, or has mailed to his last address as shown by the records of the insurer, written notice of its intention not to renew this policy beyond the period for which the premium has been accepted, a grace period of ( ) days will be granted for the payment of each premium falling due after the first

premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof)."

Reinstatement

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the day of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and the insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

To paraphrase the preceding reinstatement provisions. where formal application for reinstatement is not required. the acceptance of a premium by the company or its agent immediately reinstates the policy. If an application for reinstatement is required, the reinstatement does not take effect until approved by the company despite the payment of a premium (unless the insurance company delays its approval beyond 45 days).
Notices of Claim:

Form A may be used in any policy. Form B may be used by an insurer, at its option, in a policy providing a loss of time benefit which may be payable for at least two years. The location of such office or offices as the insurer may designate for the purpose of giving notice of claim, shall be inserted in the blank space of such provision reprinted below.

Form A

"Notice of Claim: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ( ), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."

Form B

"Notice of Claim: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given. Notice given by or on behalf of the insured or the beneficiary to the insurer at (address), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."

Claim Forms

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon

submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

It is customary for the insurer, upon receipt of the notice of accident or illness, to send a physician's certificate either to the claimant for completion by the physician or directly to the physician. Some notices of accident have a physician's certificate on the reverse side. The certificate provides the insurer with detailed information regarding the injury or illness as well as an estimate of disability.

Payment of Claims

This provision will contain a blank for insertion of the period of payment. This period must not be less frequent than monthly.

Time of Payment of Claim

Indemnities payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to the written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (__) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

A disability policy shall contain a provision which shall include the following first paragraph and which may, at the option of the insurer, include either or both of the following second and third paragraphs. If the provision contains the second paragraph, there shall be inserted in the blank an amount which shall not exceed one thousand dollars ($1,000).

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ (_) , to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

The following is an explanation of the above section: (1) Death benefits are paid to the beneficiary. If there is no living beneficiary, the benefit is paid to the estate. (2) Any balance due from benefits other than death benefits may be paid to the beneficiary or to the estate at the option of the company. (3) If there is no beneficiary or if the beneficiary is not legally competent to receive money, the company may add a "facility of payment" clause under which it may pay up to $1,000 of proceeds to any relative who appears to be equitably entitled to it. (4) Payments for benefits may be made directly to a hospital or doctor.

Physical Examinations and Autopsy

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Beneficiaries

A disability policy shall contain a beneficiary provision. At the insurer's option, the clause of such provision which precedes the first comma may be omitted.

Change of Beneficiary

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the current beneficiary or beneficiaries shall not be required to the surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Optional Disability Insurance Provisions

The following are additional uniform provisions which may be included in individual policies or not at the option of the insurer.

Change of Occupation

If the insured be injured or contract sickness after having changed his/her occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

In other words, the above section states that, under a policy containing this provision, if the insured changes to a more hazardous occupation the benefits payable will be reduced to whatever his/her premium would have

purchased had he or she been engaged in that occupation at the time of application. Conversely, if he or she changes to a less hazardous occupation, the company shall reduce the premium and refund, on a pro rata basis, the excess premium charged.

Misstatement of Age

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

Other Insurance:

A disability policy may contain a provision regarding other insurances which shall, at the option of the insurer, be in either Form A or B shown below. If Form A is used, there shall be inserted in the first blank the type of coverage or coverages and in the second blank the maximum limit of indemnity or indemnities.

Form A

"Other Insurance in This Insurer: If an Accident or Sickness or Accident and Sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ( ) in excess of $ ( ) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate."

Form B

"Other Insurance in This Insurer: Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his/her beneficiary or his/her estate, as the case may be, and the insurer will return all premiums paid for all other such policies."

Insurance With Other Insurers

If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of
loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bear" to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the like amount of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

In other words, the above sections states that, where the insured has duplicating coverage with other insurers of which he or she has not given this insurer written notice, benefits will be the pro rata proportion which this company's indemnities bear to the total benefits guaranteed by all policies. The premiums for the proportion of benefits not paid are to be refunded.

A noncancellable disability policy may contain the following provision.

Relation of Earnings to Insurance

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his or her average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under

all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars($200) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

In other words, where the insured owns disability income policies with more income benefits than his or her average income for the preceding two years, the company which includes this optional provision in its policy is liable for only the proportionate amount which the insured's actual earnings bear to the total amount of the insurance benefits. This provision may also be used in guaranteed renewable policies.

Unpaid Premium

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.
Cancellation: The Insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his or her last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

This optional provision may only be used in cancelable optionally renewable policies. This permits the insurance company to cancel the policy at any time by mailing a written notice to the insured five days in advance. In such a case the unearned premium will be refunded.

The insured may cancel at any time after the first policy period by notifying the insurer. In such event, the earned premium will be computed by use of a short-rate table. If this provision is omitted, neither the insurer nor the insured can cancel the policy during a period for which premium has been paid.

Conformity With State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Illegal Occupation

The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insureds being engaged in an illegal occupation.

Intoxicants and Narcotics

The insurer shall not be liable for any loss sustained or contracted as a consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Minimum Benefits

Most individual disability policies must also comply with requirements relating to the nature of the benefits provided. These requirements are modified from time to time and policies need only comply with the requirements in effect when they were last authorized for issue by the Commissioner. However, the Commissioner may withdraw his or her authorization for sale of a policy if it does not comply with current requirements.

Virtually all individual disability policies must comply with the Minimum Benefit Law, which establishes many requirements relating to the structure of the benefits provided. The more important of these requirements relate to:

1) the extent to which different benefits may be provided for the same loss depending on the cause of that loss;
2) extension of benefits upon policy termination by the insurer;
3) substitution of lump sum benefits for other policy benefits upon death or accidental dismemberment;
4) notice of unusually restrictive policy conditions;
5) reductions in benefits on account of age.

Many individual disability policies must also comply with the **Minimum Benefit Regulations**, which establish requirements relating to the amounts and periods for which benefits must be paid and permissible exceptions, limitations and reductions. These regulations are modified from time to time to reflect economic conditions and other factors relating to disability benefits.

Some of the more important requirements of these Regulations as of the last revision of this manual are as follows:

1) hospital confinement benefits for those under 65 must be no less than $30 per day and subject to elimination periods not exceeding 3 days;
2) elimination periods for loss-of-time benefits may not exceed 3 months, 6 months or one year, depending upon amounts payable and benefit periods;
3) accidental death and double dismemberment benefits must be no less than $1,000;
4) major medical policies must provide maximum benefits of no less than $10,000;
5) Medicare supplement policies must supplement both parts of Medicare and must provide for automatic benefit increases to reflect increases in Medicare deductibles and coinsurance factors.

The following types of individual disability policies are not subject to the Minimum Benefit Regulations:

1) supplements to government programs other than Medicare;
2) credit disability;
3) mortgage disability;
4) group conversion.

Forms and Rates

Typically, all individual disability policies and all riders, endorsements and applications to be attached to such policies must be authorized by the Insurance Commissioner before they are issued or delivered. All premium rate schedules and all occupational and substandard health classifications to be used with such policies must also be filed with the Commissioner. However, the Commissioner may not "fix or regulate rates for disability insurance". Disability benefit provisions supplemental to individual life policies must also be authorized by the Commissioner. It is unlawful to issue a form after it has been disapproved by the Commissioner. However, an unlawfully issued form is still a valid contract between the insurer and insured in most cases.

It is a crime for an insurer to discriminate among persons of the same class insured under individual disability policies. Policies issued on a selected group ("franchise") basis are partially exempt from this restriction.

No Charge if Policy Is Returned within 10 to 30 Days

Most individual disability policies must provide that the insured may return the policy within 10 to 30 days of delivery and have the premium refunded if the insured is not satisfied with it for any reason.

A policy thus returned to the company's home or branch office or the agent through whom it was purchased is void from the beginning.

Franchise policies

"Franchise" policies (also called "selected group" policies) are individual policies issued to employees of a common employer or to members of a common association. (The Insurance Code establishes certain requirements for these employers and associations.) Unlike "true group" insurance, individual insureds are usually given a choice of benefits. Premiums are usually collected by the employer, association or an entity appointed by them and remitted in bulk to the insurer. Premiums are often lower than for the same coverage issued on an individual basis because of lower administrative expenses and more predictable loss expectations because of the homogeneity of the franchise group. Traditionally, "franchise" policies have provided for automatic individual nonrenewal when an insured ceased to be an employee of the employer or a member of the association and for nonrenewal of all policies issued to such employees or members at the insured's option. However, franchise policies may be issued on a guaranteed renewable or a noncancellable basis. "Franchise" policies are treated as individual policies for all purposes except for premium rate discrimination.

GROUP DISABILITY INSURANCE

The only forms of group disability insurance are employee-employer, agent-principal, trustee, association, educational institution-student and borrower-purchaser.

Types of Group Disability Insurance

Employee-employer group disability insurance is written under a master policy issued to the employer or a trustee of an association of employers and covering employees of a governmental unit or district, employees of a common employer, or employees of the employers forming an association. The insurance must be offered to all of the employees or to all of a class determined by conditions pertaining to employment and must cover not less than 3 employees or employees together with their dependents or spouses and be on a plan which will preclude individual selection as to the amount of insurance coverage.

Agent-Principal group disability insurance is written under a master policy issued to a life or life and disability insurer and covering not less than 3 agents.

Association group disability insurance is written under a master policy issued to an association having a constitution formed and continuously maintained for purposes other than that of obtaining insurance. The insurance must be offered to all members of the association and cover not less than 3 members or members together with their dependents or spouses and at least 25 percent of all eligible members under a plan which precludes individual selection as to amount of insurance. The policy must require the premium to be paid either by payroll deduction or by some person acting for the association.

Trustee group disability insurance is written under a master policy issued to any trustees eligible to have issued to them a trustee group life policy and insuring not less than 3 employees or union members.

Educational institution-student disability insurance is written under a master policy issued to the school district, college, school or its governing board covering not less than 50 pupils of said institution and providing hospital, medical and surgical expenses resulting from accident to such students while properly on or being transported to or from the school premises or school-sponsored activities by such institution.

A certificate stating the benefits and exceptions of the master policy must be delivered to each insured employee, agent, or member (excluding dependents and spouses).

Employee-employer group policies may provide that the term "employee" includes officers, managers, and employees of subsidiary or affiliated corporation and the proprietors, partners, and employees of affiliated individuals and firms. Employee-employer group policies issued to a co-partnership or an individual employer may define the term "employee" to include the individual proprietor or partners of the policyholder. Such proprietors or partners must be actively engaged in and devote a substantial part of their time to the business. Trustee group policies may define the term "employee" to include (1) the individual proprietor and partners of any employers which are individual proprietors or partnerships, (2) the employees of an association and (3) the trustee or trustees or the employees of the trustee or trustees, or both, if their duties are principally connected with such trusteeship. Association group disability policies may define the term "members" to include the employees of the association. However, a director of a corporate employer may not become insured under a group disability policy

unless he or "he is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director.

Group Policy Provisions

Every group master policy must contain the following provisions:

1) The policy, application of the employer or representative of an association, and the individual applications, if any, of the insureds shall constitute the entire contract.

   All statements made by the employer or individual insureds shall, in the absence of fraud, be representations and not warranties.

   Such statements shall not be used in defense of a claim unless contained in a written application.

2) An individual certificate will be issued to the individual insured setting forth coverage and to whom payable.

3) A provision for the addition of new employees, members, or agents.

4) A statement that the policy is not in lieu of and does not affect any requirement for coverage by worker's compensation insurance.

5) Such forms of the "uniform provisions," or provisions not less beneficial as are promulgated and prescribed by the Insurance Commissioner.

Group disability policies are sometimes referred to as **"contributory" or "noncontributory."** If the insured members contribute part or all of the cost of the insurance the individual obtains under the policy, it is a "contributory" policy. The term "noncontributory means that the entire premium for the group policy is paid by the master policyholder, and no contributions specifically identifiable for insurance are required from the individuals.

No group disability policy shall be issued or delivered in this State unless a copy of the form is filed with and approved by the Insurance Commissioner.

Group disability policies may provide that benefits for hospital, surgical, or medical services may be reduced if the individual insured has other coverage (not including individual policies or contracts) making him or her eligible for more than 100 percent of the covered expenses. Such policies must provide that payments of funds may be made directly between the insurers providing the benefits.

Blanket Disability Insurance (including tuition refund insurance).

This type of insurance provides benefits for members of eligible groups under insurance policies issued to specified master policyholders. Individual certificates of insurance are not required to be delivered to insured members although such members may request copies of the master policy in certain cases. The operation of, any non-duplication of benefits provisions in the master-policy must be disclosed to insured members. Blanket disability insurance policies may be issued under the following circumstances:

1) To camps and educational institutions to indemnify campers or students for tuition lost due to their inability to attend because of disability ("tuition refund insurance").
2) To volunteer fire companies to provide accident benefits for members while performing membership duties.
3) To educational institutions to provide benefits for:
   a) students and their dependents.
   b) teachers or employees while performing certain special duties, such as supervision of camps, playgrounds, excursions, etc..
4) To camps to provide benefits for campers.
5) To newspapers or other periodicals to provide benefits for independent contractors engaged in the delivery or distribution of such publications.

6) To religious, charitable, recreational, educational or civic organizations to provide benefits for participants in activities sponsored by such organizations .
7) To employers to provide voluntary unemployment compensation disability insurance to their employees.

Blanket disability policies are subject to many of the Insurance Code sections applicable to group insurance and must be approved by the Commissioner before issuance.

Special Group Policy Provisions

Provisions peculiar to group insurance

1) A provision explaining which members of the group are eligible.
2) A provision determining when the insurance on the individual becomes effective.
3) A provision that a minimum number of individuals and a minimum percentage of the group must remain covered in
   order for the group policy to be renewed from term to term.
4) A provision setting forth the amounts of insurance to which individual members of the group are entitled, which amounts may be graded according to predetermined classification.
5) The causes of termination of individual coverage of members of the group.
6) If dependents are covered, a definition of "dependents" is given, and any special provisions applicable to dependents in the respects mentioned in the foregoing items as set forth.
7) Provisions relative to the duties of the master policyholder in administering the group, prescribing the records he or she must keep and the reports he or she must make to the insurer relative to the group insured.
8) A provision evidencing the insurer's obligation to provide certificates of insurance for individual insureds.

Continuation of Group Policies During Labor Disputes

Every group life or disability insurance policy where the employer pays all or a part of the premium under the terms of the collective bargaining agreement must contain a provision that the individual employees may pay the premiums and continue their coverage during the periods of work stoppages due to labor disputes.
Methods of determining the amount of each employee's contribution (premium) in such cases are provided by law.

The insurance companies are given certain rights, such as:

1) To require that contributions of the employees must be made to the company within prescribed time limits if coverage is to continue as to each such employee.
2) To increase each individual premium rate 20 percent (or higher if approved by the Insurance Commissioner) to provide for increased costs.
3) The company has the continued right to increase premium rates despite cessation of work if it had the right to do so had the work stoppage not occurred.
4) The company is not required to continue loss-of-time disability payments.
5) The company is not required to continue any coverage:
   A) Beyond the time that less than 75 percent of the employees continue such coverage.
   B) As to an individual employee, beyond the time that he or she takes full-time employment with another employer.
   C) Beyond six months after cessation of work.
6) Nothing in this law affects unemployment compensation disability insurance (U.C.D.).

Discontinuance and Replacement of Group Disability Insurance

Certain group disability insurance policies must provide extended benefits for insureds who are totally disabled at the date coverage would otherwise terminate because of termination of the master policy or because of termination of participation by an entire employer unit under a master policy insuring a number of employer units.
1) Loss-of-time and hospital indemnity benefits for employees, members and dependents must be extended until termination by their own terms.
2) Hospital, medical or surgical expense benefits for employees, members and dependents covering the

disability-causing condition must be extended for at least 12 months.

The benefits discussed in (1) and (2), above, may be subject to all limitations in the policy pursuant to which they are provided and may be terminated upon termination of total disability or upon eligibility for coverage under a replacement policy without regard to limitations as to the disabling condition.

A group hospital, medical and surgical insurance policy providing replacement coverage within 60 days from termination of a prior plan must immediately cover employees, members, and dependents who were validly covered under the prior plan and who comply with the replacement policy's eligibility requirements except for restrictions based upon employment, hospitalization or pregnancy. Persons who would otherwise be ineligible for coverage under the replacement policy because

of such restrictions must be provided with benefits no less than those provided under the prior plan. The replacement plan must cover such persons until their coverage would have terminated under the replacement policy or, where such persons are totally disabled, until the extension of benefits discussed in subparagraph (2), above, terminates. No pre-existing condition limitation in the replacement policy shall be imposed on persons validly covered under the prior plan except to the extent that benefits for a pre-existing condition would have been reduced or excluded under the prior plan.

The foregoing extension and replacement requirements apply to insurers, hospital service plans ("Blue Cross"), health care service plans and self-insured welfare benefit plans, regardless of the nature of the entity providing the coverage being replaced.

Group or blanket master policies always reserve to the insurer the right to terminate the policy. However, many such policies provide that the insurer will not exercise that right for some period, such as five years, following the issue date. Many group and blanket policies will also guarantee the premium rate to be charged for some period, such as the first one or two years of coverage. However, a group or blanket policy may provide that it can be canceled on 31 days notice to the policyholder.

Insurance on individuals covered under group or blanket master policies usually terminates upon cessation of eligibility for coverage, such as employment with the master policyholder. Individuals whose eligibility has ceased are often provided extended benefits if they are disabled. Individual conversion policies are also sometimes provided to such persons. Extended benefits must be provided to persons who are disabled when the master policy is terminated, as discussed previously.

Some group policies provide that, once an individual has been accepted for coverage, he or she cannot be individually terminated except for non-payment of premium. Of course, coverage will cease when the master policy is terminated, unless a conversion privilege is provided.

Transfer

In group disability insurance, or individual noncancellable disability policies (renewable for five years or longer which include a benefit for loss of time) the benefits may be made nonassignable by a policy provision to that effect. Otherwise a policy of disability insurance may pass by transfer, will, or succession whether or not the transferee has an insurable interest. A policy of disability insurance may be validly transferred without notice to the company unless such notice is expressly required by the policy.

DISABILITY INSURANCE UNDERWRITING

Group Underwriting

It is the usual underwriting practice to include all eligible persons regardless of physical condition or age if they apply for the coverage during the eligibility period or within 31 days thereafter. Otherwise evidence of insurability is usually required. The eligibility provisions may limit or preclude coverage past a certain age. Eligibility is customarily determined by conditions of employment or membership, and in such manner as to avoid individual selection.

Individual Underwriting

Individual disability insurance is usually underwritten on the basis of questions and answers contained in the application supplemented by inspection reports and by such information as the agent may gather for the company in the course of solicitation. The factors involved in such underwriting may be classified as follows:

1) Occupation of the applicant. Occupational classifications are usually set forth in occupation manuals issued by the insurer, and the applicant's occupation and duties should be revealed in the application in words as close as possible to those used in the occupation manual. Occupation is important primarily in loss-of-time coverages.

   Occupational hazard is the degree of danger to which a person is exposed in the performance of the occupational duties. Occupational classifications are the groupings to which the various occupations are assigned for rating purposes.

2) Health condition of insured. The application customarily makes such inquiries relative to health as the insurer deems pertinent to the type of policy under consideration. The questions may cover such factors as the age, weight, past medical history and the present state of health of the insured. The agent cannot, of course, properly ignore any health problems which become apparent during the solicitation, even though they are not specifically covered in the application.

   A medical examination may be required in connection with investigation of the past medical history shown in the application or for noncancellable policies.

The application and/or medical examination may reveal medical conditions which exist before the effective date of the policy. Such conditions are referred to as ore-existing conditions. Not all pre-existing conditions are unfavorable, but for underwriting purposes we will review how insurers handle insureds who have unfavorable medical histories.

A variety of approaches have been developed to provide disability coverage for such persons at affordable premiums. These approaches usually have one or more of the following features:

1) Excludes from coverage all losses resulting from the unfavorable medical condition.

   "Waivers", as used in disability insurance, exclude coverage for losses resulting from specified physical impairments or from specified diseases or physical conditions of which the insured's application or the insured's inspection report shows a prior history. These are commonly effected by "waiver riders" which must be signed by the insured.

2) Provide reduced coverage for losses resulting from the unfavorable medical condition. Benefit amounts may be reduced and/or special "waiting" or "elimination" periods or deductible amounts may be imposed on benefits for such losses.

   An "elimination period" is a period between the commencement of a covered disability and the date benefits become payable. Therefore, disabilities which do not last for the length of such period are "eliminated". A "waiting period" as that term is used, is a period between the policy issue date and the date coverage becomes effective for specified sicknesses or all sicknesses. It has the effect of delaying the effective date of coverage for such sicknesses. For example, suppose a policy has a six-months waiting period for "hernia". A "hernia" manifesting itself four months after the policy issue date would be treated as if it were a "pre-existing condition."

   Elimination periods are found in almost all loss-of-time policies and in some hospital indemnity policies. Elimination periods range from one day (in hospital indemnity policies) to one year (in long term loss-of-time policies).

3) Policy premiums may be increased. Substandard underwriting practices vary from insurer to insurer, depending upon the extent to which a company is willing to incur increased administrative expenses. Also,

an insurer may use different approaches to the same medical condition depending upon whether the policy covers medical treatment or loss-of-time.

Group insurance plans customarily provide only for a total exclusion of unfavorable medical conditions, but some also provide for reduced benefits for such conditions.

4) Moral hazard. The insurer may include questions in the application which the insurer believes pertinent for the underwriting of the particular type of policy applied for.

   Items covered by these questions may include information regarding the applicant's economic status, personal habits, such as use of alcoholic beverages, drugs, and the like; a past criminal record, if any; other insurance which is carried, may have been carried, or which has been denied; and claims made under other policies. The agent, of course, cannot properly ignore adverse indications of a bad moral risk with which the agent may become acquainted during the process of solicitation.

5) Economic insurability. An application for loss-of-time coverage will usually inquire into the applicants' income so that benefits may be set at a level which in conjunction with other benefits payable for disability, will not exceed the insured's after-tax income. This limit is imposed to encourage the insured to terminate the disability as soon as possible.

6) Other insurance. An application will usually inquire into what other insurance coverage or benefits are available for the losses to be covered by the policy. The general purpose of such an inquiry is to allow the insurer to set benefits so that the insured cannot profit from the disability. In hospital, medical and surgical benefits, overinsurance often results in over-utilization of medical services. Over-insurance of loss-of-time tends to discourage insureds from ending their disability.

   "Other Insurance" questions are especially important in the area of long term loss-of-time coverage" because of the availability of substantial Social Security disability income benefits. Long term loss-of-time benefits are often limited to 50% to 60% of the insured's pre-tax income and may often be programmed to reduce upon eligibility for Social Security disability benefits.

RENEWABILITY

There are two major classes of renewability provisions: those in which the insurer reserves some right to terminate the coverage and those in which the insurer guarantees to renew the policy for the insured's life or to a specified age.

The following types of renewability provisions are classified as **optionally renewable:**

1) The insurer reserves the right to terminate the policy at any time with a pro rata refund of unearned premium ("cancelable" policies);
2) The insurer reserves the right to terminate the policy at the end of any period for which premium has been paid ("non-renew") subject to prior notice ("optionally renewable"policies);
3) The insurer reserves the right to non-renew an individual policy only if it non-renews all policies of the same form number issued in the state or issued to members or employees of a specified organization. ("collectively renewable" or "non-renew-one, non-renew-all" policies);
4) The insurer can non-renew the policy only if the insured ceases to comply with one or more specified conditions, such as continued employment, employment in a specified business or profession, or continued membership in an association. Such provisions often reserve to the insurer the right to collectively non-renew all policies. ("conditionally renewable");
5) Features of two or more of the preceding types of "optionally renewable" provisions may be combined in a renewal provision.

The **two types of guaranteed renewable provisions**, "guaranteed renewable" and "noncancellable" or "noncancellable and guaranteed renewable" have been discussed previously. Some "guaranteed renewable" or "noncancellable" loss-of-time policies provide for continuation of coverage after a specified age (usually 65), on

an "optionally renewable" or "conditionally renewable" basis.

DISABILITY INSURANCE TERMS

Total disability is usually defined in terms of the insured's inability to perform the material or important occupational duties ("occupation total disability") or the inability to perform the duties of any occupation for which the insured is reasonably suited by education, training or experience ("any occupation total disability"). Most long-term loss-of-time policies contain both definitions, the former being in effect for a specified initial period of disability and the latter being in effect for the remainder of the benefit period. For example, policies providing loss-of-time benefits to-age-65 may provide that the "occupation" definition will be in effect for the first two to ten years of total disability, depending upon the policy.

Total disability for homemakers, retired persons and juveniles is usually defined in terms of the insured's inability to perform the duties of a person of like age and sex.

Partial disability is usually defined as the insured's inability to perform one or more but not all the material or important occupational duties. It may also be defined in terms of the percentage of normal working hours worked by the insured. The term "residual disability" is often applied to partial disability benefits which provide benefits proportional to the insured's loss of income due to disability. Partial disability benefit periods are generally limited to three or six months in length and often must follow a period of total disability. Residual benefits may be so limited or they may be payable for the same period as the total disability benefit, depending on the policy.

Nonoccupational policies are policies usually issued to persons whose hazardous occupations would make them uninsurable otherwise or to persons who have adequate coverage specifically for occupational injuries. Such policies exclude coverage for injuries incurred while engaged in activities for wage or profit.

Transportation ticket policies are short-term non-renewable accident policies often sold at transportation terminals or by travel agencies, often to cover a specific journey. They usually provide substantial accidental death and dismemberment benefits and often provide some medical expense benefits. Such policies are frequently issued in conjunction with a casualty policy covering loss or damage to baggage or personal effects. These coverages are usually provided on a combination policy form.

Another type of travel disability policy available through travel agents reimburses the traveler for ticket expenses incurred when he or she is prevented from embarking on or completing a charter flight because of accident of sickness.

RATES FOR DISABILITY POLICIES

The extent to which the Insurance Commissioner regulates disability insurance premiums depends on the type of insurance involved:

1) Credit disability (and life) insurance premiums are set by the Commissioner.
2) Premium rate schedules for individual disability policies must be filed with the Commissioner, but the Commissioner is prohibited by law from fixing or regulating such premiums. However, the Commissioner is empowered to withdraw authorization for future sale of individual hospital, medical and/or surgical policies if it is determined, after notice and hearing, that the rates are excessive for the benefits provided.

The Insurance Commissioner has no jurisdiction over group or blanket insurance premium rates whatsoever. Rates for these types of policies are generally negotiated between the insurers and the master policyholders and are not required to be filed with the Commissioner.

POLICY INTERPRETATION

The falsity of a statement in an application for a disability policy does not bar recovery unless the false statement was made with actual intent to deceive or materially affected either the acceptance of the risk or the hazard assumed by the insurer.

The following do not constitute a waiver of the rights of an insurer in defense of a claim under a disability policy:

1) The acknowledgment of receipt of notice given under the policy;
2) The furnishing of forms for filing proofs of loss;
3) The acceptance of such proofs;
4) The investigation of a claim.

The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this State shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall deliver or mail to the person making such reguest, a copy of such application within 15 days after the receipt of such request at its home office or branch office. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

There shall not be an alteration of a written application for disability insurance except with written consent of applicant. It is a crime (misdemeanor) to make an alteration without such consent. If the alteration is made by an officer of the insurer or by any employee of an insurer with insurer's knowledge or consent, such alteration is deemed to be performed by insurer issuing the policy upon the altered application.

If any disability policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted.

Disability policies issued contrary to law are valid but will be construed as provided by law. If a policy provision conflicts with the provisions of the law, the rights, duties, and obligations of the insurer, the policyholder and the beneficiary are governed by the law.

Any insurer or officer or agent thereof that issues or delivers a disability policy in willful violation of the law is subject to a fine not exceeding $100 for each offense. The Insurance Commissioner may revoke or suspend the license of any insurer or agent for such willful violation of the law.

LONG TERM CARE INSURANCE

Long Term Care Insurance includes an insurance policy, certificate or rider that is designed to provide coverage for diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services which are provided in a setting other than an acute care unit of a hospital.

Long Term Care Insurance includes all products containing any of the following benefits:

Institutional Care including care in a nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing facility, or personal care home.

Home care coverage including home health care, personal care, homemaker services, hospice or respite care

Community based care including adult day care, hospice, or respite care.

Long Term Care Insurance includes disability based long term care policies but does not include insurance designed primarily to provide Medicare supplement or major medical expense coverage.

HISTORY

Private long term care insurance is a recent phenomenon. Development has been slow because of barriers on both demand and supply sides.

On the demand side, there have been **three major barriers**. Historically, the elderly were disproportionately poor, unable to afford substantial premium payments. This is much less true now as the income of elderly has increased a great deal over the last twenty years, While the elderly still have the highest poverty and near poverty rates of any adult group, most current evidence suggests that the elderly as a whole are roughly as well off as the rest of the population. Most estimates of the future income and assets of the elderly project substantial improvements.

Second, most people were unaware of or denied their risk of needing long term care services. Most research suggests that persons who live to age 65 face a **four out of ten chance** of spending some time in a nursing home before they die and a **one in six chance** of spending more than one year. People seemed willing to accept the possibility that they would someday get sick and visit a doctor or be admitted to a hospital, but few people were willing to admit that they faced a significant lifetime risk of becoming disabled and using expensive nursing home or home care services.

Finally, there has been extensive misinformation. Many people think that their Medicare or their Medigap policies cover long term care. They do not.

On the supply side, there have also been several barriers. Insurers have worried about whether long term care was, in fact, an insurable risk. They worried about "moral hazard" --the increased use of services that results when people have insurance coverage. Since most long term care is currently provided by family members at no formal cost, the possible increase in use is large. This is especially true since only about 25 percent of the disabled elderly in a given community receive paid home care. Thus, there is substantial possibility of increased use of services by a large number of persons who would "medically" qualify.

In addition, insurers worried about **adverse selection** -- the possibility that people who "know" they will use long term care services will disproportionately buy the insurance, driving up use beyond expectations. This creates a vicious circle where premiums have to be raised, causing low risk people to drop their policies, forcing additional increases in premiums.

Finally, insurers have been concerned about the timing of premium payments and the ultimate use of benefits. Long term care is needed principally by the elderly, especially those age 85 and over. Thus there is likely to be a very long time between initial purchase of the insurance policy and its eventual use. For example, a policy bought at age 65 probably will not be used for 20 years; a policy bought at age 45 probably will not be used for 40 years. Unforseen changes in disability or mortality rates, utilization patterns, inflation in nursing homes and home care costs, or the rate of return on financial reserves can dramatically change a profitable policy into a highly unprofitable one.

Despite these supply and demand barriers, insurers are moving into the marketplace. Although policies are improving, most still have major restrictions. Most insurers are still being extremely cautious about who they sell policies too -- rejecting 10 to 30 percent of all people who make application is not uncommon. In essence, insurers still do not know if this will be a profitable line of business.

Restrictions

Faced with the uncertainties described above and lacking actual experience with an insured population, insurers initially tried to protect themselves against financial loss by imposing many restrictions and limitations on long term care policies. To defend against the "moral hazard" they imposed high deductibles, focused on skilled nursing care, required prior hospitalization before nursing home care and only covered home care that followed

a nursing home stay. To protect against adverse selection, insurers usually screened for health problems, did not sell to persons over age 80, and did not provide coverage for pre-existing conditions and most mental illnesses. To mitigate the general uncertainty of the future, they typically offered only fixed indemnity benefits (e.g., $50 per day in a nursing home) that did not increase with inflation. Also, insurers often reserved the right to unilaterally cancel policies.

These so-called "first generation" private long term care insurance policies were roundly criticized by unions, senior organizations and various government agencies since the net effect of the many restrictions was to substantially lessen the probability that a person who used a nursing home or home care would actually receive insurance benefits.

As time has gone on, long term care insurance policies have improved substantially. While the average policy still has some of the restrictions above, new policies provide significantly better coverage. In particular . . . prior hospitalization requirements are eliminated, policies are guaranteed renewable, Alzheimer's Disease is explicitly covered, all levels of nursing home are covered, a bit more home care is covered, and indemnity levels are indexed for inflation. Many of these changes are largely in response to state regulatory requirements and market demand by consumers rather than because insurers have gained claims-paying experience.

Regulation

The problem for regulators is how to strike a balance between protecting consumers and nurturing a new product. Proponents of strict regulation fear that if tough regulations are not imposed, consumers will not be protected against inferior products and fraud. Opponents of strict regulation argue that officials do not have enough information or experience to regulate intelligently and that flexibility is needed to prevent financial losses that may discourage the industry from providing further coverage.

In 1996, new legislation was introduced at the federal level affecting long term care policies. Congress granted long term care contracts the same status as health and accident policies in that income received under an LTC contract are excluded from income. In addition, an employer's contributions to an LTC insurance plan on behalf of an employee are excluded from gross income, unless it is part of a cafateria plan. The total amount of periodic payments received from all qualified LTC insurance contracts may not exceed a maximum of $175 per day. Any excess is includable in income.

A federal definition of an LTC contract reads as follows: ***Any insurance contract that provides only coverage of LTC services, is guaranteed renewable and does not provide a cash surrender value.*** Qualified long term care services include needed diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services as well as personal care services that are required by a chronically ill individual.

Until these changes, most regulatory activity has revolved around the National Association of Insurance Commissioners' (NAIC) Model Act adopted in 1987. Almost 30 states have adopted statutes and regulations patterned on NAIC Model Standards.

The NAIC Model Standards afford a number of protections to consumers, including:

- Preexisting condition exclusion periods of longer than six months are prohibited.

- Policies may not be individually canceled due to the age or diminishing health status of the insured.

- Purchasers have a 30-day free look period during which they may return the policy for a full refund.

- Policies may not exclude coverage for Alzheimer's disease.

- Policies may not limit coverage to skilled nursing care nor provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

- Prior hospitalization requirements are prohibited

- C Conditioning eligibility for benefits provided in an institutional care setting on the receipts of a higher levels of institutional care ("step-down") is prohibited.

- C Significant minimum standards for home health care benefits are prescribed, including prohibitions against typing benefits for home care to the need for skilled nursing, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers.

- C Individual policies must be guaranteed renewable and group products must provide for continuation or conversion of coverage. The commissioner has the discretion to approve cancellation on a statewide basis under stringent circumstances (i.e., the book of business threatens to bankrupt a company).

- C Purchases must be offered the opportunity to purchase a product with inflation protection.

- C Protections against post claims underwriting are prescribed, including a requirement that insurers keep records of policy rescissions and report them to insurance commissioners.

- C Individual policies must meet a 60 percent loss ratio.

- C A detailed outline of coverage must be delivered to all prospective applicants for long term care insurance at the time of initial solicitation.

Long Term Care Derivatives

Within the past few years, a new breed of long term care insurance has surfaced -- the long term care derivative. Derivatives are typically riders to existing policies that provide an alternative to stand alone long term care products. Benefits of these riders can nearly match the benefits of the stand alone product or fall way short. Whatever the outcome, this new approach is gaining popularity among consumers and agents who see them as a way to overcome common objectives of financially literate consumers looking to cover their long term care needs at a lower cost than stand alone insurance.

One new product approach involves a lump sum investment in a single premium life policy. A premium of $50,000, for example, might purchase $110,000 of death benefit for a female aged 65 (preferred). The company credits a current rate of return on this money. As additional incentive, the company offers a "pot of money" equal to double the death benefits ($220,000 in this case) to provide convalescent care for at least 4 years. This includes a nursing home daily benefit of $150, a home health care benefit of $75 and an adult care daily benefit of $37. These benefits begin after a 90 day elimination period and would continue as long as the insured remains eligible and until exhausted. If expenses did not use all of the "pot of money" the excess remains available thereby extending coverage into 5 or more years. Other features include 24-hour liquidity in case of other emergencies and a cancellation guarantee that promises the insured the original premium deposit, less any amounts paid for convalescent care benefits.

This new approach to long term care appeals to consumers who cannot see themselves paying years and years of long term care premiums for coverage they may never use. And, if the long term care benefits in the policy are not needed (in the case of a sudden death), their heirs are at least entitled to the death benefit.

LONG TERM CARE POLICIES

As previously mentioned, many state insurance codes have adopted NAIC standards. In addition, there are state specific laws that have been significant in shaping long term care insurance sales today. These bills have made major changes in both the definition of long term care insurance and in the design and sale of those products. Recent long term care legislation at the state level added a number of consumer provisions, did away with many of the gatekeepers that had plagued older policies, and liberalized the triggers for benefits. It has also regulated agent compensation and imposed heavy fines for improper sales practices and inappropriate replacement of existing policies.

In the following subcategories, we will look at all of these issues as they relate directly to the insurance industry, agents and their customers. ***Please check your own state codes on the following rules:***

Duration

Until the 90's long term care insurance was defined as any insurance designed to provide coverage **for not less than 12 consecutive months** in a setting other than an acute care unit of a hospital. However, specific state legislation has completely changed this definition by doing away with the **time-limited aspects** of Long Term care Insurance. Today, benefits of a Long term Care Insurance Policy are more likely to specify benefits without regard to duration of those benefits. This allows for products of short term duration and long term duration.

Advertising and Leads

IN many states an insurance company providing long-term care coverage must provide the Department of Insurance with a copy of any advertising intended for use in that state. This must be provided to the commissioner at least 30 days before the ad is actually used. The advertisement must comply with all laws of the State. Previously, these rules typically applied only to group policies issued in other states.

State laws also usually require that any advertisement designed to produce leads must prominently disclose that "an insurance agent will contact you" if that is the case.

Many leave in place the NAIC prohibition against any advertising vehicle implying any connection between the insurer and any government agency or program, such as the Social Security Administration, or implying any endorsement by governmental agencies, charitable institutions, or senior organizations.

Finally, many long term care regulations leave in the law the requirement that an agent, broker, or other person who contacts a consumer as the result of having received information from a **cold lead device** must disclose that fact to the consumer.

Brokers and Agents

Some state long term care bills require that all insurance companies submit to the Insurance Commissioner a list of all agents or other insurance representatives authorized to sell **individual** long term care insurance policies.

Insurance companies may also be required to provide continuing education on LONG TERM CARE INSURANCE and require that all agents or other insurance representatives satisfactorily complete the certain requirements as a part of, but not in addition to, existing continuing education requirements.

Topics for this continuing education must consist of, but are limited to, the following:

- State specific regulations and requirements;
- Available long-term care services and facilities; and
- Alternatives to the purchase of private LONG TERM CARE INSURANCE.

The Outline of Coverage

Agents may be required to provide a prospective applicant (the prospect) for LONG TERM CARE INSURANCE an outline of coverage (OOC) **at the time of initial solicitation** in such a way as to prominently direct the attention of the prospect to the document and its purpose. If the agent solicited the prospect, the agent must deliver the Outline of Coverage **prior to** the presentation of an application or enrollment form. In the case of a direct response solicitation, the Outline of Coverage must be provided **along with** any application or enrollment form.

The Outline of Coverage provides the following information in the order in which it is given the following section.

The Outline of Coverage clearly identifies the name, address, and telephone number of the insurance company. It must also show the policy number or group master policy and certificate number.

On page one of the Outline of Coverage the following statement is **prominently displayed**:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

The Outline of Coverage also provides the following information:

- Whether this is an individual or group policy (if group, the jurisdiction in which the policy was issued);
- The purpose of the Outline of Coverage (to provide a brief description of the important features of the policy);
- The warning that if the coverage is purchased, the client is to "READ YOUR POLICY (OR CERTIFICATE) CAREFULLY;"
- Terms which the policy or certificate may be returned and the premium refunded;
- The fact that "THIS IS NOT MEDICARE SUPPLEMENT COVERAGE;"
- The fact that neither the company nor its agents represent Medicare, the federal government or any state government;

The coverages to be provided in the policy or certificate including:

- If it is a fixed dollar indemnity policy,
- Policy limitations,
- Waiting periods, and
- Coinsurance requirements

Benefits provided by the policy or certificate including:

- Covered services,
- Related deductibles,
- Waiting periods,
- Elimination periods,
- Benefit maximums,
- Institutional benefits, by skill level, and noninstitutional benefits, by skill level;

Benefit screens or triggers in the policy or certificate must be explained for each benefit described, if applicable, such as:

- Attending physician or other certification of a certain level of functional dependency for benefit eligibility, and
- Activities of daily living (ADLs) that are used to measure an insured's need for long-term care;

For purposes of clarification, ***coverages*** *relate to the definition of what constitutes a long-term care policy while* ***benefits****, relate to exactly how the coverages will be provided.*

Limitations and exclusions found in the long term care policy such as:

- Preexisting conditions
- Noneligible facilities or providers,
- Noneligible levels of care (e.g. unlicensed providers, care or treatment provided by family members, etc.)
- Exclusions/exceptions, and
- Limitations

This section should provide a brief but specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify the benefits described in the Outline of Coverage.

The following statement may also be displayed in the Outline of Coverage following the section on Limitations and Exclusions:

"THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-

TERM CARE NEEDS."

The Outline of Coverage may also be required to provide the following information:

The relationship of cost of care and benefits, as applicable, in the following order:

- That the benefit will NOT increase over time
  any automatic benefit adjustment provisions,
- Whether the insured has a guaranteed option to buy additional benefits,
- Which benefits will be increased over time if not by a specified amount or percentage,
- If benefits will increase, whether additional underwriting or health screening will be required,
- The frequency and amounts of upgrade options,
- Any significant restrictions or limitations to upgrades, and
- Any additional premium that will be imposed;

Terms under which the policy or certificate may be continued in force or discontinued:

- Policy renewability provisions,
- Continuation/conversion provisions for group coverage,
- A description of waiver or premium provisions or a statement that there are no such provisions, and
- A statement as to whether the company has the right to change the premium and, if so, each circumstance under which it may be changed;
- That the policy provides for insureds clinically diagnosed as having Alzheimer Disease or related degenerative and dementing illnesses, and:
- Each benefit screen, or
- Other policy provisions which provide preconditions to the availability of policy benefits for policy holders so diagnosed;

Premium information to include:

- The total annual premium for the policy, and
- The portion of annual premium correspond to each benefit option if it varies with the insured's choice of options.

Any additional features of the policy or certificate such as:

- If medical underwriting is used, and
- Any other important features

On the last page of Outline of Coverage look for the following statement regarding information and counseling:

> *"The Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the Department of Insurance"*

The Sales Presentation

It has already been established that some states require an insurance agent to present an outline of coverage to a prospective purchaser of a long term care product **at the time of initial solicitation**. The agent or insurance representative must also:

- Inquire and make every reasonable effort to determine whether a prospective applicant (prospect) already has accident and sickness or long-term care insurance and the types and amounts of any such insurance;
- Refrain from twisting, using high pressure sales tactics, or using cold lead advertising;
- Refrain from any method of marketing which fails to disclose, in a conspicuous manner, that the purpose of the method is solicitation of insurance sales and that contact will be made by an insurance agent or company.

Long term care regulations typically leave in place the requirement that all brokers, agents, or other entities offering a policy or certificate of disability insurance to persons age 65 or over shall:

- Provide the prospective insured with a full and accurate written comparison with existing health coverage, and
- Shall explain the relationship of the proposed coverage to any existing health benefits provided by Medicare, Medicaid, or any other health benefits available to the applicant.

Every insurer of long-term care may need to establish marketing procedures to:

- Assure that any comparison of policies by its agents or other producers will be **fair and accurate**; and
- Assure that **excessive insurance is not sold or issued**.

Most long term care legislation leaves in place the requirement that all insurers, brokers, agents, and other engaged in the business of insurance owe a policyholder a duty of honesty and a duty of good faith and fair dealing.

Likewise, regulations typically prohibit against any insurer, broker, agent or other person causing a policyholder to replace a LONG TERM CARE INSURANCE policy **unnecessarily**. The code also presumes that nay third or greater policy sold to a policyholder in any 12-month period is unnecessary **unless** a policy is replaced for the sole purpose of consolidating policies with a single insurer.

The Application

All application for LONG TERM CARE INSURANCE, **except those which are guaranteed issue**, shall usually contain clear, unambiguous, short, simple questions designed to ascertain the health condition of the applicant.

- Each question shall contain only one health status inquiry.
- Each question shall require only a "yes" or "no" response.

The application may include a request for the name of any prescribed medication and the name of the prescribing physician. However, any mistake or omission on the part of the prospect **may not be used as the basis for a denial of a claim or the rescission of a policy or certificate**.

The following warning may need to be printed close to the applicants signature block and must be conspicuous:

"Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage."

LONG TERM CARE INSURANCE application forms may also contain a question designed to determine whether or not the proposed insurance is intended to replace any other accident and sickness LONG TERM CARE INSURANCE presently in force. A separate form designed to require the prospects may be used.

If the insurer, other than an insurer using direct response solicitation, determines that he sale will involve replacement of an existing policy, a notice must be provided to the applicant. The notice must be in the following form:

"**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE"**

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance coverage to be issued by (company name) Insurance Company. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information factors which may affect the insurance protection available to you under the new coverage.

(1) Health conditions you may presently have (preexisting conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present coverage.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical history. Failure to include all material medical information on an application may provide a basis for the company to deny any future been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

____
_____________________ (Date)

____
(Applicant's Signature)"

One copy of this notice is typically retained by the applicant and an additional copy, signed by the applicant, is retained by the insurer.

Most state long term care rules leave in place the requirement for the insurers using direct response solicitation to provide this same notice to the insured upon issuance of the policy or certificate changing only the final paragraph which must be read:

To be included only if the application is attached to the policy or certificate). If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, read the copy of the application attached to your new coverage and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (company name and address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

____
(Company Name)"

For group coverage not subject to the 30-day return provision, the notice may be modified to reflect the time period in which the policy may be returned and the premium refunded.

Except when the replacement coverage is group insurance, the replacement notice typically includes the following statement:

"COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current long-term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

_______Additional or different benefits
(Please specify)____________.
_______No change in benefits, but lower premiums.
_______Other (Please specify)__

____

(Signature of Agent and Name of Insurer)

____
(Signature of Applicant)

____
(Date)"

Long term care legislation will generally place the following restrictions to the amount of premium which may be collected at the time an application for LONG TERM CARE INSURANCE is taken. The insurer:

- May not require an amount greater than **one month's premium** to be submitted with an application if interim coverage is not provided;
- May not require an amount greater than **two month's premium** if interim coverage is provided;
- Must notify the applicant within 60 days from the date the application and initial premium are received of whether or not the coverage is approved; and
- Must pay interest on premium received with the application if notification is not made within the specified time.

Finally, long term care regulations typically leave in place the prohibition against knowingly recommending or selling disability insurance directly to a Medi-Caid beneficiary who is age 65 or older. The application or other supplemental record signed by the applicant must contain a question designed to determine if the applicant is receiving Medi-Caid benefits.

Policies and Certificates

Under many state rules, any policy or certificate in which benefits are limited to the provision of institutional care shall be called a "**nursing facility only**" policy or certificate.

- The words "Nursing Facility Only" must be prominently displayed on page one of the policy and the Outline of Coverage

- The Commissioner may approve alternative wording if it is more descriptive of the benefits.

Any policy or certificate in which benefits are limited to the provision of home care services, **including community-based services** shall be called a "**home care only**" policy or certificate.

- The words "Home Care Only" must be prominently displayed on page one of the policy and the Outline of Coverage.

- The Commissioner may approve alternative wording if it is more descriptive of the benefits.

Only those policies or certificates providing both institutional care and home care benefits may be called "**comprehensive long-term care**" insurance.

A certificate for group LONG TERM CARE INSURANCE which is delivered or issued may need to include:

- A description of the principal benefits and coverage provided in the policy,
- A statement of the principal exclusions, reductions, and limitations contained in the policy,
- A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued.
- A statement of the terms under which the insurer has a right to change premiums,
- A statement that the group master policy determines governing contractual provisions, and
- An explanation of the insured's rights regarding continuation, conversion, and replacement.

Most state rules on long term care leave in place the requirement that an applicant for LONG TERM CARE INSURANCE, other than an applicant for a group certificate, shall have the right to return the policy or certificate

by first-class United States mail **within 30 days of its delivery** and to have the premium refunded of, after examination of the policy or certificate, the applicant is not satisfied **for any reason**. The return shall void the entire transaction as if it had never occurred. All premiums and any policy fees shall be refunded directly to the applicant **within 30 days** after the policy or certificate is returned. A notice to this effect must be prominently printed on the first page of the applicable policy or certificate.

The Benefits

Typically, state specific rules on long term care prohibit any LONG TERM CARE INSURANCE policy delivered or issued which requires any of the following preconditions for benefits. LONG TERM CARE INSURANCE policies and certificates **MAY NOT:**

- Require prior hospitalization as a condition for receiving benefits,
- Require a prior and higher level of institutional care as a condition for receiving institutional care benefits,
- Require prior institutionalization as a condition for receiving benefits for community-based care, home health care, or home care, or
- Require a prior institutional stay of more that 30 days as a condition of eligibility for nay other noninstitutional benefits (*i.e. other than community-based care, home health care, or health care*).

Home Care Only and comprehensive policies must provide **all** the following benefits:

- Home health care (skilled nursing or other professional services in the residence);
- Adult day care (medical or nonmedical care on less than a 24-hour basis in a licensed facility, outside the residence, for persons in need or personal services, supervision, protection, or assistance in sustaining daily needs). Daily needs include:

  -Eating,
  -Bathing,
  -Dressing,
  -Ambulating,
  -Transferring,
  -Toileting, and
  -Taking medications;

- Personal care [assistance with the activities of daily living (ADLs) including the instrumental activities of daily living (IADLs) provided by a skilled or unskilled person under a plan of care developed by a physician or a multi disciplinary team under medical direction].

  ADLs include:
  -Eating,
  -Bathing,
  -Dressing,
  -Ambulating,
  -Transferring,
  -Toileting, and
  -Continence;

  IADLs include:
  -Using the telephone,
  -Managing medications,
  -Moving about outside,
  -Shopping for essentials,
  -Preparing for meals,
  -Laundry, and
  -Light housekeeping;

- Homemaker services (assistance with the activities necessary to or consistent with the insured's ability to

remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multi disciplinary team under medical direction);

- Hospice services (outpatient services not paid by Medicare that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal illness, and provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or multi disciplinary team under medical direction); and
- Respite care [short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home. This is a separate benefit with its own conditions for eligibility and maximum benefit levels (read: this is whatever the insurers want to put into the policies)].

Interestingly enough, many state rules on long term care do not in any way define, list, or specify what institutional benefits are or must consist of.

Home care benefits **may not be limited or excluded** by any of the following:

- Requiring a need for care in a nursing home if home care services are not provided.
- Requiring that skilled nursing or therapeutic services be used before or with unskilled services.
- Requiring the existence of an acute condition.
- Limiting benefits to those provided by Medicare-certified providers or agencies.
- Limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law.
- Defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.
- Requiring **medical necessity** or similar standard as criteria for benefits.

Every comprehensive long-term care policy or certificate that provides for both institutional care and home care and sets a daily, weekly, or monthly benefit payment maxim of the maximum for institutional care may need to pay a maximum benefit for home care that is at least **50 percent** of the maximum benefit for institutional care.

No home care benefits may be paid at a rate that is less than **fifty dollars ($50)** per day.

Insurance products approved for residents in continuing care retirement communities are typically exempt from this provision.

If the benefits in a comprehensive policy or certificate sets durational maximums for institutional care, they must allow durational limits for home care that are at least **one half** of the length of time allowed for institutional care. How the insurers are going to determine how much home care an insured is entitled to under a lifetime policy remains to be seen. Most long term care legislation leaves in place the requirement that insurers must offer policy holders of LONG TERM CARE INSURANCE policies the option to purchase a policy that provides for benefit levels to increase to account for probable increases in the cost of long term care services. The **inflation protection** must be no less favorable than one does the following:

- Increases benefit level annually;
- Guarantees the insured the right to periodically increase benefit levels without providing evidence of insurability or health status as long as the option for the previous period has not been declined; or
- Covers a specified percentage of actual or reasonable charges.

<u>The Triggers</u>

Most long term care regulations leave in place the fact that any insurer offering LONG TERM CARE INSURANCE **may** require a written declaration by a physician, independent needs assessment agency, or any other source of independent judgement **suitable to the insurer** that services are necessary before any benefits are paid for. This provision is **permissive**. It is **not mandatory**. It allows the insurer to impose a 'medically necessary' clause in their policy unless that is specifically precluded elsewhere in the Insurance Code. For purposes of this legislation, this section could apply to all benefits **except** home care. Medical necessity has been

specifically precluded from that benefit.

In every policy or certificate that provides home care benefits, the eligibility for those benefits may be **no more restrictive than** the client meeting either of the following two criteria:

- Impairment in **two** activities of daily living (ADLs)
- Impairment of cognitive ability.

A policy may provide for the lesser eligibility criteria but not more. The Commissioner may approve other criteria or combinations of criteria if the interests of the insured are better served.

Other Consumer Protections

Long-term care insurance **MAY NOT**:

- Be canceled, nonrenewed, or otherwise terminated on the grounds of age or the deterioration of the mental or physical health of the policy or certificate holder;
- Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form with the same insurer except when there is an increase in benefits voluntarily selected by the insured;
- Provide coverage for **skilled nursing care only** or provide more coverage for skilled care in a facility than for lower levels or care;
- Limit benefits for diagnosed destruction of brain tissue with resultant loss of brain function; i.e. progressive, degenerative, and dementing illness including Alzheimer's;
- Provide payments based on a standard described as "usual and customary", "reasonable and customary", or words to that effect.

If a policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall **waive any time periods applicable to preexisting conditions and probationary periods** to the extent that they have been satisfied under the original policy or certificate.

Long term care regulations typically leave in place the fact that no LONG TERM CARE INSURANCE **benefits may be reduced** because the insured, family members, or nay other individual made out-of-pocket expenditures on behalf of the insured.

Further, legislation in the long term care arena typically provide for the extension of benefits beyond termination for institutionalization if the institutionalization begins **while the LONG TERM CARE INSURANCE** is in force and **continues without interruption** after termination. This constitutes **waiver of premium** and **may be limited to**:

- The duration of the benefit period, or
- Payment of the maximum benefits.

This extension of benefits may be subject to any policy waiting period and another applicable provisions of the policy.

Underwriting

If an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted with the application before issuing the policy or certificate, the insurer may only rescind the policy or certificate or deny an otherwise valid claim if there is clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant. The evidence must:

- Pertain to the condition for which the benefits are sought;

- Involve a chronic condition or involve dates of treatment before the date of application;
- Be material to the acceptance for coverage.
- No long-term care policy or certificate may be field issued.
- The contest ability period for LONG TERM CARE INSURANCE is two years.
- A copy of the completed application must be given to the insured when the policy or certificate are delivered.

Every insurer must maintain a record of all policy certificate rescissions, both state and countrywide, except those voluntarily initiated by the insured. This information must be submitted to the Commissioner annually.

The Gatekeepers

If a LONG TERM CARE INSURANCE policy or certificate contains any limitations with respect to preexisting conditions, those limitations must appear in a separate paragraph and must be labeled as "**preexisting condition limitations**."

State long term care legislation will typically leave in place the following restrictions to what gatekeepers an insurance company can impose regarding preexisting conditions. Their definition of preexisting conditions may be no more restrictive than:

- A condition for which advice or treatment was recommended by, or received from a provider of health care services within six months preceding the effective date of coverage on an insured person.

No LONG TERM CARE INSURANCE policy or certificate, other then an employers group policy, may exclude coverage for a loss or confinement which is the result of a preexisting condition unless that loss or confinement begins within six months following the effective date of coverage of an insured.

The Commissioner may extend the limitation periods discussed above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and using that information for underwriting.

Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, **need not be covered**, until the waiting period described above expires.

Unless specifically approved by the Commissioner, no LONG TERM CARE INSURANCE policy or certificate may exclude, limit, or reduce coverage for specifically named or described preexisting diseases or physical conditions beyond the waiting period described above. No riders or waivers of any kind may be used to get around this prohibition.

A LONG TERM CARE INSURANCE policy or certificate containing any limitations or conditions for eligibility must have a separate paragraph with a description of those limitations and conditions, **including any required number of days of confinement**, and must label that paragraph "**Limitations or Conditions Eligibility for Benefits**."

State regulations on long term care usually leave in place the fact that no policy delivered or issued for delivery in this state as LONG TERM CARE INSURANCE may limit or exclude coverage by:

- Type of illness,
- Treatment,
- Medical condition, or
- Accident, **except as to the following**:
  -Preexisting conditions or diseases,
  -Mental or nervous disorders (except Alzheimer's, and dementing illnesses),
  -Alcoholism and drugs,
  -Illness, treatment, or a medical condition arising out of any of the following:
  -War or act of war, whether declared or undeclared,

-Participation in a felony, riot, or insurrection,
-Suicide, whether sane or insane, attempted suicide, or intentionally self-inflicted injury,
-Aviation in the capacity of a non-fare-paying passenger,
-Treatment provided in a government facility, unless otherwise required by law,
-Services for which benefits are available under Medicare or other government programs (**except** Medicaid),
-Services provided under any state or federal worker's compensation, employer's liability or occupational disease law,
-Services provided under any motor vehicle no fault law,
-**Services provided by a member of the covered person's immediate family**, or
-Services for which no charge is normally made in the absence of insurance.

<u>Renewability</u>

Individual LONG TERM CARE INSURANCE policies may need to contain a renewability provision. The provision must:

- Be appropriately captioned:
- Appear on the first page of the policy;
- Clearly disclose the term of coverage for which the policy was first issued;
- State the terms and conditions under which the policy may be renewed;
- State whether or not the issuer has the right to change the premium; and
- If this right exists, the circumstances under which the premium may change.

Every other long-term care policy issued to an individual (*such as group coverage*) may need to contain a provision which makes it either guaranteed renewable or noncancelable. Those are defined as follows:

- **Guaranteed renewable** - The insured has the right to continue coverage in force as long as the premiums are paid on time. The insurer **may not**:
- Unilaterally change the terms of coverage, or
- Decline to renew.
- The insurer **may**, if the terms of the policy allow, change premium rates for all insureds in the same class.
- **Noncancelable** - The insured has the right to continue coverage in force as long as the premiums are paid on time. The insurer **may not**:
  Unilaterally change the terms of coverage,
  Decline to renew, or
  Change the premium rates.

Every long-term care policy and certificate must contain an appropriately captioned renewability provision on **page one** which describes the initial terms of coverage **and** the conditions of renewal and, where applicable, a description of the class and the circumstances under which the insurer may change the premium.

<u>Continuation and Conversion</u>

Continuation coverage means the maintenance of coverage under an existing group policy when that coverage would be or has been terminated and which is subject **only** to timely payment of the premium.

Conversion coverage means an individual policy of LONG TERM CARE INSURANCE issued by the insurer of the terminating group coverage:

- Without considering insurability, and
- Containing benefits that are identical to, the equivalent of, or better than the group coverage that has been terminated.

Before issuing conversion coverage **the insurer may require**, subject to giving adequate notice, that:

- The individual must have been continuously insured under the group policy, or nay policy it replaced, for at least six months,
- The insured must submit written application for conversion within a reasonable period of termination of the group coverage,
- The conversion policy contains a provision for reduction of benefits if the insured has other insurance and the combination of the two would provide benefit payments more than 100 percent of incurred expenses, provided the reduction in benefits also reflected a reduction in premiums, and
- The conversion policy contains limiting payment for benefits needed at the time of conversion tot he same amount that would have been payable under the previous group coverage.

Every certificate of group insurance issued or delivered in most states must provide for continuation or conversion coverage for the certificate holder if the group coverage terminates for any reason except the following:

- The insured's failure to pay the premium when due;
- The terminating coverage is replaced not later than 31 days after termination by new group coverage effective the day after the old coverage terminated and the new coverage:
- Provides identical, equivalent, or better benefits than the old coverage, and
- The premium for the replacement coverage is calculated on the insured's age at the time of issue of the original coverage.

Replacement

If a group long-term policy is replaced by another policy issued to the same master policyholder (the group), the replacing insurer most likely needs to:

- Provide benefits identical or substantially equivalent to the terminating coverage (*lesser or greater coverage may be provided if the Commissioner determines that it is the most advantageous choice for the beneficiaries*),
- Calculate the premium on the insured's age at the time of issue of the group certificate being replaced (the previous insurance),
- If the insurance being replaced was previously replaced, calculate the premium on the insured's age at the time the previous policy was issued, and
- If the replacement coverage adds new increased benefits, the premium for those benefits may be calculated on the insured's age at the time of issue of the new coverage
- Offer coverage to all persons covered under the replaced group policy on its date of termination,
- Not exclude coverage for preexisting conditions if the terminating group coverage would have provided benefits for those preexisting conditions
- Not require new waiting periods,
- Not require ne elimination periods,
- Not require new probationary periods,
- Waive any such time periods applicable to preexisting conditions to the extent that similar preconditions have been satisfied under the terminating group coverage, and
- Not vary the benefits or the premiums based on the insured's
    - -Health,
    - -Disability status,
    - -Claims experience, or
    - -Use of long-term care services.

Other Special Long Term Care Rules

Additional regulatory provisions surfacing in state legislation on long term care include the following:

- The insurer must declare that a replacement policy **materially improves** the position of the insured (this does not apply to replacement coverage of group policies).

C Every long term care insurer must file it's commission structure or an explanation of its compensation plan with the Commissioner.

C Any amendments to the commission structure must be filed with the Commissioner.

C Every insurer or entity marketing Long Term Care Insurance must establish auditable procedures for complying with the agent and representative continuing education provisions.

C Fines and other penalties for brokers, agents, and other entities, other than insurers, who violate provisions of new regulations.

C Provisions that benefits under Long Term Care Insurance shall be deemed reasonable in relation to premiums if the expected loss ration is at least 60 percent (60 cents of each premium dollar goes to pay benefits).

C No group Long Term Care Insurance coverage may be offered or sold to a resident of this state under a group policy issued in another state unless the insurer accomplishes an information filing with the Commissioner which includes a specimen master policy and certificate, a corresponding outline of coverage and representative advertising materials to be used in this state.

LONG TERM CARE PARTNERSHIP PLANS

Many states have launched a cooperative program between the state and a select number of private insurance companies. These insurers have agreed to offer long term care policies that meet standards set by the Partnership and the state.

Types of Partnership Policies & Features

Two types of Partnership policies are available: policies that cover only care in a facility (residential care facility and nursing home care) or policies that cover care at home, in the community, as well as residential and nursing facility care.

Insureds choose between these types of policies and the amount of coverage desired. Policies generally offer coverage from 1-5 years and offer the following features:

C Automatic inflation protection to ensure that benefits keep pace with rising costs of care.

C A once in a lifetime deductible

C Care coordination services

C Waiver of premiums while in a nursing home or residential care facility.

C Interchangeable policy benefits so that care can be customized.

Asset Protection

Unlike private long term care policies, Partnership coverage includes a special asset protection feature designed to assure that catastrophic long term care expenses will reduce an insured's assets to certain protected levels if insurance benefits run out.

This asset protection feature works as follows:

1) Partnership-approved private long-term care insurance policies pay for care in the same as traditional long term care policies;

2) Unlike traditional policies, each dollar paid out by a Partnership policy entitles the insured to keep a dollar of assets if Medi-Caid services are needed.

Thus, when long term care insurance benefits run out an insured can apply for Medi-Caid assistance to pay for continued care without having to “spend down” savings and assets as normally required by Medi-Caid.

TRADE PRACTICES

REPRESENTATIONS

A representation is a statement of past, present or future fact or a statement of opinion or belief to the best of one's knowledge. Factual statements must be absolutely true; others must be substantially true. A representation is a part of the inducement to enter into the contract and, if false in a material way, provides grounds for the injured party to void the contract.

A representation may be oral or written, and may be made at the time of, or before, issuance of the policy. A representation is false when the facts fail to correspond with its assertions or stipulations, and may be altered or withdrawn before the insurance is effected but not afterwards. If a representation is false on a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time representation becomes false. Materiality is determined not by the event, but by the probable and reasonable influence of the facts upon the party to whom the representation is made in forming his or her estimate of the disadvantages of the proposed contract.

In life and disability insurance, all answers in an application for life or disability insurance are, in the absence of fraud, deemed to be representations and not warranties. A representation based on the best knowledge and belief of the insured will not void a life or disability policy.

CONCEALMENT

Concealment is the neglect to communicate that which a party knows, and ought to communicate. Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance. Each party to a contract of insurance shall communicate to the other, in good faith, all facts within his or her knowledge which are, or which he or she believes to be, material to the contract. Materiality is determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his/her estimate of the disadvantages of the proposed contract.

Examples in life insurance

Insured's failure to disclose his/her medical history is a concealment of "material facts" and could void a life insurance contract.

Life insurance applicants' failure to disclose conditions of which they were unaware does not stop recovery under the policy.

Examples in fire and casualty

Application for a fire policy in the name of a nonexistent corporation, instead of correct corporate name was concealment and material misrepresentation, stopping recovery under a policy.

WARRANTY

A warranty is a statement of fact which must be literally true. Violation of a material warranty by one party to a contract entitles the other to rescind.

A warranty may be express or implied.

An express warranty is a statement in a policy of a matter relating to the person or thing insured, or to the risk,

as a fact. Every express warranty made at or before the execution of a policy shall be contained in the policy, or in another instrument signed by the insured and referred to in the policy, as part of the policy.

Implied warranty is a representation, not in writing, that insurable conditions exist. Implied warranty is included in the policy even though not specifically stated.

MISREPRESENTATION OF POLICIES

An insurance licensee shall not use any oral or written misrepresentation of:

1) The terms of a policy issued by any insurer.
2) The benefits or privileges of a policy issued by any insurer.
3) The future dividends of a policy issued by any insurer.

Proof that an insurance licensee made false representation of one or more of these facts is a misrepresentation. These misrepresentations entitle the insured to void the contract.

Twisting is any misrepresentation that:

1) Induces or tends to induce a person either to take a policy or to refuse to accept a policy of one insurer and instead take out a policy with another insurer; or

2)
2) Induces or tends to induce a policyholder to lapse, forfeit or surrender his or her insurance.

A licensee shall not make any representation or comparison of insurers or policies to an insured which is misleading, for the purpose of inducing or tending to induce him or her to lapse, forfeit, change or surrender his or her insurance, whether on a temporary or permanent plan. Misrepresentation can occur by acts or omission when comparing two policies.

A licensee that violates any provisions relating to concealment, misrepresenting, or twisting may have his or her license suspended or revoked for a period not exceeding three years. In addition, the licensee may be fined or imprisoned for a period not exceeding six months.

A person may not refuse to testify about misrepresentation or twisting on the constitutional grounds of self-incrimination. If that person is compelled to testify, that person may not be prosecuted for the acts that person was required to testify about, except for perjury.

UNFAIR PRACTICES

No person shall engage in this State in any trade practice which is defined as, or determined to be, an unfair method of competition, or deceptive act or practice in the business of insurance. The following acts or practices are defined as unfair or deceptive:

1) Misrepresenting the terms, benefits or advantages of a policy, the past or future dividends or share of surplus received under a policy. Misrepresenting the legal reserve system upon which a life insurer operates. Using a policy name or title which misrepresents the true nature of the policy. Making a misrepresentation to induce a policyholder to terminate his or her insurance.

2) Making misrepresentations about the business of insurance or the manner in which any person or company conducts his or her insurance business.

3) Engaging in any boycott, coercion or intimidation resulting in monopoly or unreasonable restraint in the business of insurance.

4) Misrepresenting the financial condition of an insurer.

5) Making misrepresentations with intent to deceive regulatory authorities about an insurer's financial condition.

6) Unfairly discriminating among people of like class in life or annuity insurance rates.

7) Advertising that insurers are members of a state insurance guarantee association.

Should the Insurance Commissioner determine after notice and hearing that a person has engaged in any unfair or deceptive practices, the Commissioner may order that person to cease and desist from engaging in those acts or practices. If the Insurance Commissioner, after a hearing, determines that a person has violated a cease and desist order, the Commissioner may order the person to pay a fine for the first violation as follows:

1) $5,000.
2) In case of a willful violation, $55,000.

For any subsequent violation of a cease and desist order, the Insurance Commissioner may, after hearing suspend or revoke the license of that person for a period not exceeding one year.

DISCRIMINATORY PRACTICES

The Insurance Commissioner has adopted regulations dealing with discrimination in the availability of insurance based on sex, marital status or sexual orientation. A person engaged in the business of insurance in this State is prohibited from discriminating in the availability of insurance by:

1) Refusing to issue any contract of insurance or canceling or declining to renew a contract.
2) Restricting, modifying, excluding or reducing the amount of benefits payable, or any term, condition or type of coverage.

No insurer may discriminate, in the availability of all lines of insurance, based upon a person's sex, marital status or sexual orientation. <u>Rate discrimination based on these factors is permissible.</u>

No life, or life and disability insurer can discriminate, <u>in availability of coverage or rates charged</u>, based on a person's race, color, religion, national origin or ancestry. No insurance application or investigation report used to determine insurability shall carry any identification of these factors.

UNFAIR CLAIMS PRACTICES

The insurance code in most states lists the following as unfair claims practices:

1) Misrepresenting pertinent facts or policy provisions in settling claims;

2) Failing to promptly acknowledge, investigate, process or settle claims upon which liability is reasonably clear;

3) Failing to affirm to deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured;

4) Compelling insureds to institute litigation to recover amounts due by offering substantially less than the amounts ultimately recovered;

5) Attempting to settle claims for amounts substantially less than would have been expected from advertising materials;

6) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent or broker;

7) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;

8) Compelling insureds to accept settlements less than the amount awarded in arbitration by making known to them a practice of the insurer of appealing such awards;

9) Requiring multiple filings of proofs of loss which contain substantially the same information;

10) Delaying settlement of claims under one portion of a policy so as to influence settlements under other portions of the policy;

11) Failing to provide explanations of the basis for the denial of claims;

12) Advising claimants not to engage attorneys;

13) Misleading a claimant as to the applicable statute of limitations.

FRAUDULENT CLAIMS

It is a criminal act to make a false or fraudulent claim under an insurance policy or assist in the preparation or presentation of a false or fraudulent claim under a policy. Any licensed person guilty of such act may have his or her license suspended or revoked. Violators of this provision may be imprisoned in the state prison for two, three or four years or fined up to $10,000 or both.

ANTI-COERCION

It is unlawful for any person engaged in the business of financing the purchase of, or of lending money on the security of, real or personal property to require, as a condition precedent to such financing, that the borrower or purchaser place any insurance on such property through a particular insurance agent or broker. This shall not prevent a lender from exercising his or her right to furnish such insurance as is required by the contract if the borrower or purchaser shall have failed to furnish it within such reasonable time as may have been specified in the sale or loan contract. The fact that insurance by an acceptable insurer provides more coverage than required in the sale or loan agreement is not grounds for refusal to accept it, unless the additional coverage consists of automobile, life or disability insurance. The Savings and Loan Commissioner, the Superintendent of Banks and the Corporations Commissioner, in conjunction with the Insurance Commissioner, have issued regulations defining reasonable cause upon which a lender may refuse to accept insurance policies. Consult state insurance codes.

A borrower or purchaser is entitled to a free choice of insurance agent or broker at any time and he or she may revoke any designee of insurance agent or broker at any time irrespective of the provisions of any loan, purchase agreement or trust deed.

When the borrower or purchaser fails to deliver insurance or renewal of insurance required by the sale or loan contract at least 30 days prior to the expiration of a policy, the lender may furnish or renew such insurance and charge the account of the borrower or purchaser with the cost.

If an insurance policy procured by the borrower or purchaser is substituted less than 15 days prior to the expiration date of the one then in force, or subsequently, the lender may impose a maximum service charge of $5 for the substitution of insurance policies.

A lender is not prevented from recommending to a borrower or prospective borrower the placing of insurance with a specified insurer or through a specified insurance agent or broker. Such recommendation shall be in writing and must clearly show the name and mailing address of the recommended insurer, agent or broker.

The Insurance Commissioner may investigate any person, whether licensed or not, for the purpose of determining if there has been any violation of these provisions; however, if such investigation be upon a

complaint, the complainant must be a party to the contract of sale, trust deed, or loan agreement and must make such complaint within three months of the execution of any modification.

The Insurance Commissioner may, after hearing, suspend or revoke any license held by any person who violates the above provisions.

FREE INSURANCE

No insurer shall participate in any plan to offer or effect any kind of kinds of insurance or annuities in this State as an inducement to buy or rent any property or service, without any charges to the insured for the insurance. No insurance licensee shall arrange for the sale of free insurance.

This shall not apply to insurance written in connection with:

1) Subscriptions to newspapers of general circulation.
2) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in that credit union.
3) Insurance offered as a guarantee of the performance of goods.
4) Insurance designed to protect the purchasers or users of goods.
5) Title insurance.
6) Life or disability insurance written in connection with an indebtedness, when the purpose of insurance is to pay the balance of the indebtedness in the event of the death or disability of the person insured.
7) Services provided to members of a motor club

DISCIPLINARY ACTION

Persons licensed by the Insurance Commissioner to transact insurance in this State must carefully obey all insurance laws, rules and regulations. Violation of these laws, rules and regulations could result in the revocation, suspension or restriction of licenses and, in some cases, criminal prosecution of the licensees in the courts.

The Insurance Commissioner may suspend or revoke a license after a hearing on the grounds that:

1) The licensee is not qualified to perform the duties required of the licensee.
2) The holding of the license if against public interest.
3) The licensee is not actively and in good faith carrying on an insurance business with the general public.
4) The licensee does not have a good business reputation.
5) The licensee is lacking integrity.
6) The licensee was refused a professional, occupational or vocational license, or had such a license suspended or revoked by any licensing authority.
7) The licensee holds the license for the purpose of avoiding or preventing the operation or enforcement of the insurance laws of this State.
8) The licensee knowingly or willfully made a misstatement in the application to the Commissioner for a license, or in a document filed in support of the application, or has made a false statement in testimony given under oath before the Commissioner or any person acting in his stead.
9) The licensee engaged in a fraudulent practice or act or conducted any business in a dishonest manner.
10) The licensee has shown incompetency or untrustworthiness in the conduct of any business, or committed a wrongful act or practice in the course of any business which exposed the public to danger of loss.
11) The licensee knowingly misrepresented the terms or effect of an insurance policy or contract.
12) The licensee has failed to perform a duty expressly required by the Insurance Code, or has committed an act expressly forbidden by the Insurance Code.
13) The licensee has been convicted of:
    a) A felony;
    b) A misdemeanor denounced by the Insurance Code or other laws regulating insurance; or
    c) A public offense having as one of its necessary elements a fraudulent act or act of dishonesty in acceptance, custody or payment of money or property.
14) The licensee aided or abetted any person in an act or omission which would constitute grounds for suspension, revocation or refusal of a license to be issued to the person aided or abetted.

15) The licensee has permitted any person in his/her employ to violate any provision of this Insurance Code.
16) The licensee has violated any provision of law relating to conduct of business which could lawfully be done only under authority of a license.

The Insurance Commissioner may, with or without hearing, suspend, revoke, deny, or refuse to renew a license on grounds that:

1) A licensee committed a felony as shown by a final judgment of conviction.
2) A licensee committed a misdemeanor denounced by the Insurance Code or other laws regulating insurance as shown by a final judgment of conviction.
3) A licensee had a previous license suspended or revoked for cause within five years.
4) A licensee had an application denied for cause within five years.

The Insurance Commissioner may as a disciplinary measure for violation of the Insurance Code suspend, revoke or restrict a license.

REVOCATION/SUSPENSION OF LICENSE

If a license is revoked, the Insurance Commissioner may not, for the period of one year, issue a license to the licensee concerned.

Action may be taken against a license held by an organization based on the acts of a natural person named to transact under the organizational license, the Insurance Commissioner may revoke or suspend the license of the organization and all licenses and licensing rights of the natural person.

If a solicitor or other employee of a licensed insurance licensee violates insurance laws, the license of the employer may also be revoked or suspended if it is determined that the employer permitted the violation.

The Insurance Commissioner may offer a licensee found in violation of any insurance laws a choice of either a fine or a suspension or other penalty. The amount of the fine may not exceed:

1) $1,000 for a single offense, or
2) $5,000 for all counts in one proceeding, or
3) 30 percent of the gross premiums on insurance transacted by the licensee during the preceding calendar year.

If the licensee elects the fine and does not pay it within the time specified, his or her license may be revoked or suspended by the Insurance Commissioner.

As a disciplinary measure when a violation of the insurance laws would justify suspension, revocation or denial of license, the Insurance Commissioner may issue a restricted license. The term "restricted license" means a license which is restricted by reasonable conditions relating to its acquisition or the conduct of its holder, and which may be suspended or revoked without hearing or cause.

After any hearing involving the suspension, revocation or denial of a license, the Insurance Commissioner may order the licensee to prove his or her qualifications by taking and passing the qualifying examination for the license held. Failure of the examination by the licensee shall result in the termination of all licenses to which the examination applied.

IMPORTANT NOTE: A licensee may violate the insurance law by any acts committed, or by acts omitted or failure to perform any duties required of the licensee.

INSURANCE COMPANIES

Insurers can be classified in many ways. For the purposes of preparing for the licensing examination, we have classified the insurers into four groups:

domicile, admission status, legal form of organization, and by classes of insurance written.

DOMICILE

Insurers may be domestic, foreign, or alien.

A domestic insurer is organized under the laws of a specific state, whether or not admitted to do business in that state.

A foreign insurer is an insurer not organized under the laws of specific state, but in one of the other states within the United States, whether or not it is admitted to do business in that state.

An alien insurer is an insurer organized under the
laws of any jurisdiction other than a State of the United States, whether or not admitted to do business in a specific state..

ADMISSION STATUS

An admitted insurer is one which has received a certificate of authority from the Insurance Commissioner permitting it to transact specified classes of insurance business in a specific state. All other insurers are nonadmitted insurers and not entitled to transact insurance in that state. An admitted insurer may be either a domestic, foreign or alien insurer.

LEGAL FORM OF ORGANIZATION

Insurers have two classes of organization. First, private enterprises that are corporations organized on a capital stock basis known as stock insurers. Second, those private enterprises organized as cooperative enterprises, including mutual insurers, reciprocal (interinsurance exchanges), fraternal benefit societies, and county mutual fire insurers.
Stock Insurer: is a corporation owned by individuals who contribute capital through the purchase of stock. The stockholders elect the board of directors who, in turn, appoint the executive officers. The gains or losses from the operation are shared with the stockholders through dividends declared by the board of directors and through the increases or declines in the market value of their shares of stock. Most stock insurers issue nonparticipating policies which do not entitle the insured to participate in the profits or earnings of the insurer. A few stock insurers are doing business on the "mix plan" where they issue both nonparticipating and participating policies.

Mutual Insurer: is a corporation owned by its policyholders. These policyholders elect the board of directors who, in turn, appoint the executive officers. The policyholders are entitled to share in any profits earned by the insurer. The earnings, if any, are returned to the policyholders in the form of a refund on their premiums, commonly called a "dividend". Those policies that entitle the insured to a dividend are called participating policies.

or Reciprocal Interinsurance Exchange: is an unincorporated association that enables individuals, and business firms, to insure one another. The policy-holders are both the insured and the insurer. Each policyholder agrees to insure all of the other policyholders in the association and, in turn, is insured by each of the other policyholders. These associations are managed by an attorney-in-fact, appointed by the policyholders and empowered on their behalf to bind them to one another.

Fraternal Benefit Societies: are authorized under special sections of the state insurance code to conduct the business of insurance providing benefits to members and their families in the event of accident, sickness or death. Fraternal societies usually are incorporated without capital stock. Membership is required in the society to purchase insurance from the society.

Mutual Fire: Two hundred and fifty or more persons residing in a particular county may incorporate for the purposes of forming a mutual fire insurer. The policies issued, by a county mutual
fire insurer, shall have a minimum amount of $1,500,000 aggregate coverage with a minimum premium of $15,000. In an entire state there is not likely to be more than a dozen mutual fire insurers.

CLASSES OF INSURANCE WRITTEN

An insurer may not transact any class of insurance which is not authorized by its Articles of Incorporation or its charter, nor can an insurer transact any class of insurance in a state without first being admitted. An insurer can become an admitted insurer by securing a Certificate of Authority from the Insurance Commissioner to transact a class or classes of insurance. Therefore, insurers can be classified according to the classes of insurance for which they are admitted.

Life Insurer - an insurer issuing policies in one or more of the classes of life, disability, liability, workers' compensation, common carrier liability, and no others. Few life insurers transact other than life or life and disability insurance.

Multi-Line Insurers - an insurer doing business covering several insurance classes, such as fire, marine, and general casualty lines. This insurer cannot transact life, title, mortgage, or mortgage guaranty insurance.

Title Insurer - an insurer that is limited to transacting title insurance.

Mortgage Insurer - an insurer that is limited to transacting mortgage insurance.

NOTE: While several mortgage insurers are admitted for this class of insurance, this class has not been written for many years.

Mortgage Guaranty Insurer - an insurer that is limited to transacting mortgage guaranty insurance.

MARKETING SYSTEMS USED BY INSURERS

In insurance, "marketing" is the method used by insurers to inform potential buyers about the various contracts that are available. Three types of marketing systems are used by insurers: (1) the independent agency system, (2) the exclusive agency system, (3) the direct mail system. Most admitted insurers are marketing their contracts under one of these three systems. The role of the broker in marketing will also be discussed at the end of this section.

1) The independent agent is a person who enters into agency agreements with more than one insurer. This agreement gives the agent ownership of the business written by the agent. This ownership allows the agent to place the insurance with any insurer he/she represents, he/she can transfer the insurance from one insurer to another if he/she or the insured becomes dissatisfied with an insurer. The agent is also able to transfer the insurance if the insurer is unhappy with the insured. The independent agent generally receives a higher rate of commission than the exclusive agent, but the agent must finance his/her own agency. The cost of office space, secretarial help to prepare contracts and send out renewal notices will be paid by the agent.

2) The exclusive agent is a person who enters an agency agreement to represent one insurer, or a group of insurers who have common ownership. This agreement generally prohibits the agent from representing any other insurer and gives ownership of the business to the insurer. If the agent should leave the insurer to work for another insurer, the book of business is kept by the insurer and given to another agent to service. The exclusive agent cannot give the insureds a choice among insurers. Technically, exclusive agents are not employees of the insurer, but independent contractors paid a commission for contracts written. The insurers provide services to their exclusive agents, such as providing office space, clerical support, preparing the contracts, sending out renewal premium notices and handling most, if not all, claims.

NOTE: The Insurance Code makes not distinction between an independent agent and exclusive agent when a license is being issued to a person. The authority granted under the agents license is the same in either case, but the agency contact entered into by the agent with an insurer will determine whether the agent is independent or exclusive.

3) The direct mail systems does not depend on an agent. The insurers market their contracts from the home

office. These insurers offer their contracts to the public through direct mail campaigns, newspaper and magazine advertising. The person who is interested in these contracts normally will write for information, which the insurer returns with an application to be filled out and returned. Presently, this system accounts for a very small percentage of insurance being written.

These three methods of marketing are used by the insurers and their authorized agents. One other method of marketing that should be mentioned is the broker. In most states, the broker is the representative of the insured who, in effect, does the insured's insurance shopping. Brokers have no agency contracts with the insurers, but place business with those admitted insurers which will accept the offer by the broker. A person may be licensed as both an agent and broker. When a person is licensed as an insurance agent and broker, that person is required to act as an agent for those companies for which that person is appointed as an agent. He or she may act as a broker only with those insurers for which that person is not appointed as their agent.

POLICIES

INSURANCE CONTRACTS IN GENERAL

The definition of insurance as given in Insurance Codes defines insurance as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event." it is important that a licensee understand the meaning of this definition. In order to obtain a good understanding, it is necessary to be able to identify and know the meaning of following terms in this definition:

Contract: an agreement to do or not to do a certain thing that is enforceable by law.

Indemnify: to make payment in money or property, to compensate for a loss.

Contingent: the peril that might occur and cause damage or liability against a person.

Unknown event: Perils could include fire, windstorm, hail, explosion, flood, theft, riot, vandalism, negligence, failure to satisfy and obligation to another person.

"Insurance" generally may be defined as an agreement by which one person for a consideration promises to pay money or its equivalent, or to perform some act of value, to another on the destruction, death, loss, or injury of someone or something by specified perils.

Insurance policies are contracts, therefore they must meet the requirements of other legal contracts. The essential elements needed to make contracts enforceable are:

1) Capable parties - all persons are capable of contracting except minors, persons of unsound mind, and persons deprived of civil rights. The exception in making a contract of insurance is that a person under the age of 18 is competent to contract for life or disability insurance or an annuity contract on his/her own life for the benefit of himself/herself or members of his/her immediate family. A person under 16 years of age nearest birthday must have the written consent of parent or guardian to enter into an insurance contract (see examples under insurable interests).

2) Consent - must be given freely, mutually and communicated by each party to the other. Consent is given between two parties when a proposal or offer by one of the parties is made and the other party accepts.

3) Lawful subject - agreement shall not call for the violation of any laws. In insurance, lawful subject is any contingent or unknown event, whether past or future, which may cause damage to or create a liability against a person having an insurable interest. The Insurance Code expressly prohibits insurance on a lottery or the outcome of a lottery, and policies executed by way of gaming or wagering.

4) Consideration - any benefit given to a party by the other party which was not lawfully due the party. In insurance, the consideration is the monies which are given as premiums.

While these elements are essential to contracts in general, there is one more requirement that is necessary to contracts of insurance. In insurance, the insured must have **an insurable interest** in the lawful subject of the contract.

The Insurance Code defines insurable interest in property insurance as "every interest in property, or any relation thereto, or liability in respect thereof, of such a nature that a contemplated peril might directly damnify the insured." Lack of insurable interest causes the contract to be void. In fire and casualty insurance, the requirement of an insurable interest in property must exist when the insurance takes effect and when the loss occurs, but need not exist in the meantime. The measure of insurable interest in property is the extent to which the insured might suffer financial loss by damage to or loss of the property.

The Insurance Code defines insurable interest in life and disability insurance as "every person has an insurable interest in the life and health of (1) himself/herself (2) any person on whom he/she depends wholly or in part for education or support (3) any legal obligation to him/her for the payment of money or respecting property or services of which death or illness might delay or prevent payment (4) any person upon whose life any estate or interest vested in him/her depends."

1) Himself/Herself - every person 18-years or older that is capable of entering into a contract may apply for insurance on his/her own life in any amount. The amount of life insurance in force on any one life is not limited by law, but is normally a negotiable term limited by underwriting requirements of a company. These requirements may vary from company to company, while one company's limit of insurance in force on any one life may be $100,000 another's limit might be unlimited.

When a person, 18-year or older, purchases a policy of life insurance on his/her own life, the law does not require that the beneficiary have an insurable interest.

A person under age 18 is competent to contract for life or disability insurance or an annuity contract on his/her own life for the benefit of himself/herself or the benefit of the father, mother, husband, wife, child, brother or sister.

A person under 16-years of age, nearest birthday, must have written consent of parent or guardian to enter into an insurance contract. If assessments are involved in the insurance of any minor, the liability for assessment must be assumed by the parent or guardian by a written agreement.

2) Any person on whom he/she depends wholly or in part for education or support. - A wife has an insurable interest in her husband. The husband has an insurable interest in his wife. The children have an insurable interest in their parents.

3) Any person under legal obligation to him/her for the payment of money or respecting property or services, of which death or illness might delay or prevent the performance - A creditor has an insurable interest in the life of a debtor. When a person owes money or property to another person, the person to whom the debt is owed has an insurable interest in the life of the person owing that debt to the extent of the amount owed.

APPLICATION

Except in a few specialized types of insurance, the selection of risks is based upon comprehensive applications signed by the insured in which he/she is required to answer searching questions from which the company determines insurability. In many cases, life insurance applications are supplemented with medical examinations. These are subject to being supplemented or checked by a report to the company by the soliciting agent and by the inspections made for the company by other than the agent.

No contract exists between an applicant for insurance and an insurance company until the application for insurance is accepted. An application for insurance is a proposal which does not become an enforceable contract until it is accepted by the insurer on the terms in which the proposal was made. If the insurer alters any terms of the proposal, then the applicant must accept the alterations before the contract is effective.

Company requirements for applications vary depending on the type of insurance and the authority given to the

agent by the company. For some types of insurance, a written application may not be required. For these coverages, an applicant may request coverage orally and the agent may create an oral contract by immediately binding the requested coverages. When the agent has this authority, the agent should understand what makes an oral contract of insurance valid and enforceable. It is necessary that both the agent and the applicant agree to the company providing coverage, subject matter, risk, premium, duration of risk and amount of insurance. Specifying the company providing coverage at this time is important to an agent if he/she represents more than one company. Failure to do so can result in each company that the agent represents paying a pro rata share of a loss that might occur before a written binder or policy is issued, and possibly the agent may be held responsible for the loss. Whenever the parties enter into an oral contract before the policy has been issued, the policy should be backdated to the date of the oral contract. An agent should use extreme caution when using his/her authority to enter into an oral contract. The difficulty of providing the terms of an oral contract or its existence makes it advisable to confine contractual agreements to those that are written whenever possible.

Other types of insurance that are more complex require a written application, even though an agent may have issued a binder to provide temporary coverage. In these cases, the company wishes to know about particular details, which allows it to determine if the risk meets its underwriting standards. If the risk meets the underwriting standards, the company may issue the policy, or inform the agent to issue the policy depending upon the method used for issuing policies by that particular company. When the risk does not meet the underwriting standards, the company must cancel any temporary binder that was issued in the same manner it would cancel a policy that has been in force.

NOTE: When the agent prepares the application for the insured, the agent is doing so as the agent of the insurance company, and not the agent of the insured.

BINDERS (COVER NOTES)

Binders may be issued to bind insurance temporarily pending the issuance of the policy. Within 90 days after issue of a cover note, a policy shall be issued, including terms and premiums identical to those bound by the cover note. An insurer may extend a cover note beyond 90 days with the written approval of the commissioner for a period which, when added to the original 90-day period, will not extend coverage beyond 150 days. A risk must fall into one of the following categories to be eligible for extension without written approval from the commissioner.

1) The property insured is in five or more separate locations.

2) The premium is estimated to be:

   (A) $400 or more annually in the case of fire insurance.
   (B) $250 or more annually in the case of insurance other than fire.
   (C) The risk is one which requires an inspection and is located in excess of 100 miles from a city with a population of 100,000 or more.

Cover notes and all extensions must be in writing. The insurer must maintain a permanent record of the original covering note and all extensions. The cover note must contain the following:

1) Name of the insured,
2) The property or liability insured,
3) The amount of insurance,
4) The perils insured against,
5) The effective and termination dates,
6) The basis or rates upon which the premium is to be determined and paid,
7) If cover note is extended, the extension must identify the original note.

A policy must be issued covering the insured, after a risk has been bound by a cover note, with the same effective date which was provided in the cover note. When the policy is issued for a period of time that extends beyond the period of coverage in the cover note, the earned premium may be included in the premium charged under the policy. When the period of coverage provided by a cover note does not extend beyond that provided

by the cover note, a policy shall be issued showing the time coverage was in force and premium charged for the insurance.

POLICIES IN GENERAL

A policy is either open or valued. An "open policy" is one in which the value of the subject matter is not agreed upon, but is left to be determined in case of a loss. Under an open policy, the measure of indemnity is the expense to the insured of replacing the thing lost or injured in its condition at the time of its loss or injury. A "valued policy" is one which expressed, on its face, an agreement that the thing insured shall be valued at a specified sum. Whenever the insured desires to have a valuation named in a policy insuring any property, the insured may require such property to be examined by the insurer and the value shall be fixed at that time by insured and insurer. The cost of this examination shall be paid by the insured. A clause shall be inserted in such a valued policy, stating that the value of the insured's property has been fixed by such an examination. In those valued policies that do not make the stipulation "not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality", the insurer shall pay losses as follows:

1) In case of a total loss, the amount stated in the policy.
2) In case of a partial loss, the full amount of the partial loss.

In various classes of insurance, different policies or contract provisions are used. However, a degree of uniformity exists in the basic provisions of the policies issued by a majority of insurers. There are certain provisions which are common to many lines. In general, these policies usually contain five parts known as "declarations", "insuring agreement", "exclusions", "conditions", and "miscellaneous provisions". Only the definition of these parts is given this portion; they will be reviewed in more detail in the portion of this manual dealing with the specific policies.

Declaration:- is a term applied to underwriting information identifying the insurer and insured, subject matter, premium or how the premium will be determined, policy limits, policy term, and a list of forms that make up the body of the contract. In some policies, the perils will be listed in the declaration, but in most policies, other than the standard fire policy, the perils are listed in the body of the contract. The declaration normally appears on the first page of the contract.

Insuring Agreement - states what it is the insurer agrees to cover under the terms of the contract. It will refer to the subject matter of the insurance. In the standard fire policy, the declaration and insuring agreement will appear together on the first page of the contract. In those policies that have more than one subject matter, such as homeowner policies, there will be an insuring agreement for each subject matter.

Exclusions - These provisions in a policy will fix the limits on the promises of coverage stated in the insuring agreements. These provisions serve one or more purposes, including elimination for coverage of (1) coverage for losses caused by certain perils, (2) coverage provided by other insurance, (3) coverage of uninsurable losses. Basically, exclusions are those portions of the insurance contract which limit the scope of the coverage and/or list causes and conditions which are not covered.

Conditions - Those provisions in a policy which call for the insured to do something, or not to do something, either before or after a loss has occurred. The insurer's obligation to pay for losses or to provide services is based on the insured's obligation to perform certain duties, or prevent certain things from happening. One of the duties of the insured, before a loss, is to have been truthful in applying for the insurance coverage. Concealment or fraud by the insured will make the policy void. One of the duties of the insured, after a loss, is to protect the property from further loss. Failure to do so could relieve the insurer of the obligation to pay the claim.

Miscellaneous Provisions - Those provisions which, along with the declaration, insuring agreement, exclusions and conditions complete the insurance policy. These provisions help to establish working procedures for carrying out the terms of an insurance policy.

ENDORSEMENTS

An endorsement is an agreement not contained in the original policy. It may be written on or attached to the

policy, thus becoming a part of the policy. Historically, when written on a separate piece of paper and physically attached to the policy, it was originally called a "rider" and, when written on the policy itself, it was originally called an "endorsement". These terms are now used interchangeably.

When a policy has conflicting provisions between a policy and endorsement (rider) the following will normally apply. A contract will be interpreted, if at all possible, so as to give effect to the intent of the parties who executed it. If the conflicting provisions can be reconciled, they will be so interpreted as to give effect to every part of the contract. If they cannot, the following rules, considering only typography, are a generally applied:

1. An endorsement (rider) added after the execution of the policy will prevail over the original policy terms whether they are printed or written.
2. The terms of a printed rider attached at the time the policy was issued will generally prevail over the printed part of the policy, but the assumption is not as strong as in (1) above.
3. A written part of the policy, having been especially chosen to express the agreement of the parties to the contract, will prevail over the more general printed portion or printed endorsement (rider).

THE BUSINESS OF INSURANCE

Although procedures and techniques change over time, the underlying goal of any insurance company is solvency and growth. Staying focused on this goal is often complicated by the ebb and flow of intense issues like premium rate wars, politically inspired regulatory compliance and even government mandates. Still, insurers must carry on with the ***business of insurance*** -- collecting premiums, paying claims and investing capital. Beyond pure financial planning, the business of insurance must contend with the ***nature of the business*** itself. Property-casualty insurance, for instance, is a highly cyclical business that does not necessarily coincide with the general economy. The reasons involve factors of competition, fluctuating investment performance, regulatory delays, rate restrictions and, of course, unexpected catastrophes courtesy of mother nature. Life insurance companies too, are experiencing wider swings in business than in years past due to pressures of competition (insurance and non-insurance based), investment troubles and regulatory restrictions. The most significant shift in the way insurers do business, however, involves regulatory and rating agency concentration on ***operational performance*** and reinsurance. In essence, how companies make money and how much money they owe is becoming more meaningful indicator of solvency over the singular magnitude of what they own.

HOW INSURANCE COMPANIES MAKE MONEY

Overview

When laymen think of an insurance company, it is easy to conjure a world of actuarial precision--the uncanny ability to project the future through sophisticated formulas and mathematical prophecy. Few purchasers of insurance, for instance, are knowledgeable on the subjects of mortality tables, experience ratings, the law of large numbers and probability analysis. Given the vast resources and long histories of insurance companies, it is no wonder the average insurance consumer believes that ALL insurers represent "mega-business" conglomerates with unlimited profit potential.

Students of how insurance company's make money, however, are more likely to see the industry from a much different perspective -- where uncertainty runs high and where profitability can be wiped out in a blink of an eye. They consider mortality to be an evolving concept and experience rating levels something to be shattered by new, more spectacular catastrophes that bend our imagination beyond all belief. For example, the increased mortality of the flu epidemic of 1918 caused insurance companies of that era to lose an equivalent of one year's annual profit and render some company's temporarily insolvent. One can only imagine how modern day diseases such as AID's will affect the "bottom line" as the fatalities compound and companies are required to take "all comers" regardless of pre-existing conditions. In another instance, property and casualty claims filed from Hurricane Andrew amounted to almost 20 times the annual premium collected by all insurers in the State of Florida

combined. This is also equivalent to the amount of premium collected by all property/casualty insurers nationwide for one full year! Other examples include the Midwest Floods, the California earthquakes. Add to this the day to day struggle insurers confront concerning fraud, groundless lawsuits, growing compliance laws and the ups and downs of stock and bond portfolios and it is easy to see that the business of making money is a constant challenge for insurers large and small.

Basic Money Making

For all forms of insurance, the ***primary source of income*** is the still the premium. Since most accounting considers insurance contracts to be annual in nature, a company tracks its ***written premium*** (an annual figure) versus its ***earned premium*** (1/12th the total written premium if collected monthly, ½ if semi-annual, etc). Losses for insurance companies include ***incurred losses*** as well as loss adjustments and there are operating expenses (commissions, overhead, taxes, etc). What remains, if anything, is the ***underwriting gain***. Determining profit at any one point in time is difficult because each insurer has thousands of policies with varying maturities. So, companies use estimated "ratios" to measure ongoing performance. There are ***loss ratios*** -- the ratio of actual losses and loss adjustments compared to earned premiums--and there are ***expense ratios*** -- the ratio of expenses to written premium.

In addition to their "book of business", insurance companies make money from ***investment profits***. In the past, an acceptable investment strategy for insurance companies involved moderate mixing of well diversified risks like real estate and some higher risk bonds. Because premium income was predictable, longer maturity investments, with corresponding higher yields, were common in most portfolios. In recent years, however, the need to improve profitability caused insurers to seek the same high yields in shorter term or more liquid investments (junk bonds). Ultimately, these holdings became the subject of regulatory action and in some cases policyowner panic. Needless to say, insurers will have a tough time producing high investment yields in the years ahead.

Another consideration affecting profitability is competition. Sometimes, insurers sacrifice their own profits to build business. In the mid 1980's, for example, major price wars between insurers were launched in an attempt to build volume. At times, insurance was so cheap that premiums did not cover claim payments. But for years, such losses hardly mattered because the growing volume of premium dollars coming in to the company were plowed into investments that brought bigger dividends and interest payments. Also, the losses from operations turned out to be great tax shelters to offset high yielding investments. This is because insurers were able to take a percentage of their losses as a tax credit. Companies at the time were racking up millions in tax credits or so-called "paper profits". In fact, a survey among insurance companies in 1984 found that about 40 percent of all property and casualty companies attributed 68 percent of their operating income to tax credits.

Measuring Profitability

It is apparent, that there are several source of income for insurance companies. And, insurer profitability can be measured through a variety of financial tests. A few used by A.M. Best are as follows:

CASUALTY COMPANIES

Combined Ratio After Policyholder Dividends : The sum of the loss ratio, expense ratio and dividend ratio. This ratio measure's a companies underwriting profitability. This ratio does not reflect investment income or income taxes. For companies underwriting predominantly property risks, the normal range for this test is from 95 to 105. For companies underwriting predominantly long-tailed liability risks, the normal range is from 100 to 110. A higher than 105 for property insurers and 110 for liability insurers is considered above the accepted norm for this test.

Loss Ratio : The ratio of incurred losses and loss adjustment expense to net premiums earned expressed as a percent.

Expenses Ratio : The ratio of underwriting expenses (including commissions) to net premiums written expressed as a percent

Operating Ratio (IRIS) : The combined ratio less the Net Investment Income Ratio. The Net Investment Income Ratio is the ratio of net investment income to net premiums earned, expressed as a percent. This ratio measures a company's operational profitability. The operating ratio does not reflect realized and unrealized capital gains or income taxes. The normal range for this test for all types of insurers is currently from 85 to 95. Above 95 is considered normal. This is also one of the IRIS tests (Insurance Regulatory Information System), developed by the National Association of Insurance Commissioners in 1974.

NOI to NPE Before Taxes : The percent of net operating income to net premiums earned before taxes. The normal range is from 3 percent to 6 percent. A ratio below 3 percent is considered poor profitability.

Yield on Invested Assets (IRIS) : Net investment income as a percent of cash and invested assets plus investment income minus borrowed money. This ratio does not reflect realized and unrealized gains or income taxes. The normal range for this test is 6 percent to 8 percent. A poor rating is under 6 percent. This is another IRIS test adopted by the National Association of Insurance Commissioners.

Change in PHS (IRIS) : The change in policyholders surplus from the prior year. Lower than 5 percent is considered poor. The normal rage is from 5 percent to 10 percent.

Return on PHS : The ratio of all operating income, after taxes and realized gains and unrealized investment gains, to the prior year policyholders surplus. Under 5 percent is considered unacceptable. Normal ranges run from 5 percent to 15 percent.

LIFE COMPANIES

Benefits Paid to NPW : This ratio takes total benefits paid as a percentage of net premiums written. A range of 45 percent to 70 percent is average.

Commissions & Expenses to NPW : Here, commissions and expenses are compared to net premiums written. The average is from 30 percent to 55 percent.

Net Operating Gain to Total Assets : This ratio is the net operating gain (after taxes) as a percentage of the prior year admitted assets. A range from 0.5 percent to 1.5 percent is normal.

Return on Equity : This is net operating gain (after taxes) as a percentage of prior year capital and surplus. Companies should average from 8 percent to 14 percent.

Net Operating Gain to Net Premiums Written : This test measures earnings (net operating gain after taxes) in relation to a company's current net premiums written. A range of from 3 percent to 7 percent is considered normal.

Change in Capital & Surplus : A change in capital and surplus is important to track from year to year. A change lower than 5 percent is below average. Most companies average 5 percent to 15 percent.

Property-Casualty Profits

In the early days, property-casualty companies wrote only ***property insurance***, beginning with marine type insurance and later expanding into fire insurance. Liability insurance was not written until the last half of the 1800's. Today, liability insurance constitutes an increasing proportion of the industry's premium. The shift from property to liability is significant because ***liability insurance*** requires higher loss and unearned premium reserves. More reserves, in turn, means more funds to invest and reserves are the industry's largest sources of investment capital. In taking this one step further, the profit and capital gains from investments is an important component of insurer profitability. Another major source of investment earnings comes from policyholder surplus. Surplus is the second largest source of investment capital. Surplus is also critical in determining an insurer's capacity to write insurance and collect premiums. Many states, for instance, require property-casualty carriers to have $1 of surplus for every $2 of net premium written. The National Association of Insurance Commissioners allows $3 premium for every $1 of surplus. It stands to reason then, that having a large surplus

permits a higher volume of business to be written, which can mean more profits as well as greater potential earnings from investments.

Life Company Profits

Until the 1970's, low inflation and level interest rates helped to stabilize cycles in the life insurance industry. The primary product was whole life insurance. ***Premiums were predictable*** and, yielding a steady cash flow. Insurers needed only to invest to keep ahead of the relatively low 3 percent to 5 percent being paid credited to cash values. Higher interest rates, rampant inflation and a more competitive playing field changed all that. Beginning in the late 1970's, new insurance products had to be developed and insurance company managers had to find higher yielding investments. With money market accounts yielding more than 10 percent, it was easy to see why many policyowners "cashed-in" their policies to invest elsewhere. Deregulation in other financial areas, namely banking, caused serious problems for life companies since they could market variable interest accounts that automatically increased when t-bills or other indicators rose. The life industry did not acquire this privilege of "interest sensitive" accounts until 1980 when the National Association of Insurance Commissioners created the Model Standard Valuation and Nonforfeiture Law. This opened the door for universal-type policies which skyrocketed to popularity in the early to mid 1980's -- universal's share of total industry premium during this period went from a low 2 percent to almost 40 percent. Then came variable life, universal-variable life, single premium whole life, a resurgence in annuities and guaranteed investment contracts.
(GIC's).

All of these policy derivatives ***changed*** how life companies made money. For one thing, policyowners have become quite a bit more transient than when whole life was the dominant choice. If another, more competitive rate appears, they may surrender and move. So, company managers have lost the predictability of their premium income. Therefore, they are not able to commit to long term investments as they did in the past. In addition, they now assume greater interest rate risks. A swing in interest rates, for example, may require a life company to sell a portion of their bond portfolio at a bad time. In both instances, investment yields can be significantly lower.

WHAT INSURANCE COMPANIES OWN AND INVEST IN

Assets

A major restructuring of insurance companies during the late 1980's and early 1990's has put an entirely new face on insurer balance sheets. Equally significant is the trends sought by regulators and industry groups concerning how insurer assets are valued and the type and ratio of investments allowed. The story begins with assets. Insurers have ***admitted assets*** (investments, real estate owned and data processing equipment) and ***nonadmitted assets*** (unsecured loans, prepaid expenses, agent advances, furniture, supplies, office equipment, etc). A solvency analysis of a company would focus on admitted assets which are more easily converted to cash. Nonadmitted assets might take considerably longer to liquidate or they may be entirely unmarketable. An investment analysis would delve into the company's risk/return profile including the desired bond duration, the mix between stocks and bonds, the mix between taxable and tax-exempt bonds, international diversification and real estate (loans and real estate owned). The combination of solvency and investment analysis is the most difficult task now before asset/liability managers. In essence, they walk the fine line between satisfying regulatory requirements and meeting stockholder expectations.

The most common tests involving insurer ownership and liquidity include the following A.M. Best formulas and ratios:

Quick Liquidity : Quick assets (cash, short term investments, short term bonds, government bonds of five years or less, and 80 percent of common stocks) divided by net liabilities (total liabilities less conditional reserves plus real estate encumbrances less any negative liabilities) PLUS ceded reinsurance balances owed. This ratio measures the proportion of net liabilities covered be cash and investments which can be quickly converted to cash. A normal range for casualty companies is considered to be from 30 percent to 50 percent. Life companies operate at 75 percent to 90 percent levels.

Current Liquidity (IRIS) : Cash plus invested assets and encumbrances on other properties compared to net

liabilities plus ceded reinsurance owed. This ratio measures the proportion of liabilities covered by cash and investments. A number less than 100 percent means that a company's solvency is dependent on the collectibility or premiums and sale of investments. A ratio lower than 120 percent is considered poor for property insurers. Liability companies, however, can operate at levels between 100 and 120 with normal results. Life companies test in the 95 percent to 110 percent range.

Operating Cash Flow : The ratio of funds generated from an insurer's operations, excluding dividends, capital injection, unrealized stock gains/losses and non-insurance gains/losses. This test would measure a company's ability to meet its obligations internally. Any negative balances would be considered poor.

Investments

As a general rule, ***insurance companies invest*** only after they have met their surplus and reserve requirements (discussed below). Investments outside reserve and surplus funds lean toward interest bearing or income producing investments that are non-speculative in nature. While most states do not specify where excess funds must be invested the undertone is conservative. The State of New York, for instance, provides a listing, they call Section 1405, of appropriate choices. They include: Government obligations issued by the United States, the District of Columbia, any territory of the United States; obligations and preferred shares of U.S. institutions (corporation, association, trust company, partnership, joint venture); obligations secured by liens on real property located within the United States; investments in real property located in the United States; and personal property located or used in the United States which is held directly or evidenced by partnership interest, stock, trust, etc.; common shares of United States institutions and certain Canadian and other foreign investments. New York also allows some leeway in this scenario, sometimes referred to as the ***basket provision*** whereby an insurance company may invest a certain percentage (no more than 3 percent of admitted assets) in investments that do not quite fit Section 1405 classification.

In addition to this, many states have special provisions relating to the amount of ***investment*** an insurer may make ***in a subsidiary*** or other insurance company. New York Insurance Code 1701 directly prohibits a life insurance company from organizing or acquiring a bank, trust company, savings and loan, credit union, sales finance company or any other company engaged in the business of financing or accepting deposits that may be insurable by any federal or state insuring agency. Further, New York insurers may not invest in any subsidiary where its total aggregate investment would exceed 10 percent of admitted assets. Investments in other insurance companies or insurance subsidiaries are exempt from this limitation. Beyond this, some states restrict insurance company investment by the type of investment. Examples include preferred and common stock, where investments in a single company must not exceed 4 percent of admitted assets. And, not more than a total of 20 percent of all admitted assets can be invested in common stocks (New York).

Surplus

Before insurers can write business or make investments, they must meet minimum capital and surplus. Far and away, the most important measure of an insurer's capacity to function is surplus. ***Policyholders' surplus*** is the difference between an insurer's total admitted assets and liabilities -- i.e., net worth. It is also the principal measure of an insurer's financial cushion for policyholders when insurance company results turn sour. Increases in policyholder surplus reflect an insurer's ability to provide security. Each state is different as to the levels of surplus required. Surplus requirements also vary depending on the line or lines of business an insurer is authorized to write. Even once established, regulators strictly control the type of cash or cash equivalents that make up surplus. Typically, these investments are limited to investments in cash, U.S. Government securities, or securities (bonds) of the state in which the insurer is domiciled. In New York State, insurance companies must keep not less than 60 percent of the amount required as capital and surplus in cash or cash equivalents similar to those described above. Once capital and surplus requirements are met, an insurer is permitted to invest its funds in a broader range of securities and investment products. These options range from corporate bonds and preferred and common stocks to real estate and mortgage loans, as well as to the more speculative investments like junk bonds, financial futures and put and call options.

Overall, the trend in policyholders surplus is still increasing, but at a very slow pace. For example, the rise in surplus during the year 1992 was only 2.7%--about one-fifth the previous year. For the most part, this decline was due to unprecedented losses suffered by casualty companies (Hurricane Andrew, etc). So great were these

catastrophes that in the same year, the industry suffered its first operating losses in over seven years. The fact that surplus increased is directly attributed to the actions that management has vigorously pursued during 1992 and 1993. To offset losses, insurers have sought capital contributions from their parent companies, sold real estate holdings and liquidated a large part of their bond portfolios, which prospered well in the late 1980's and early 1990's. The gains on these sales have, for now, "shored-up" company surplus. Of course, this is nothing new. Insurer's have often fallen back on their investments to recover from major underwriting losses. In past situations, however, inflation kept real estate prices and bond yields high. This time around, as the industry recovers from its losses, subsequent profits will be reinvested at lower rates. Further, it may take many years for the real estate market to recover before insurers will again consider it an option. So, there will be fewer investment gains in the years ahead to offset future surplus problems. In essence companies will have to contend with weakened balance sheets.

Reserves

Reserves come in several different flavors. Property and casualty companies maintain ***unearned premium reserves, loss reserves and voluntary reserves***. Life companies maintain ***policy reserves***. The basic premise of a reserve is to "stock-up" capital to cover anticipated losses. Property and casualty companies need unearned premium reserves to provide for the return of premium or pro-rata share thereof when a policyholder cancels. Reserving for unearned premiums is particularly hard on insurers because they are usually required to show the full amount of the liability and the amount allowed for expenses is usually spread over the term of the policy when, in fat, it is all paid within the first year. For these reasons, unearned premium reserves are generally an overstated. Loss reserves, on the other hand, are a little more practical in application. They cover claims that have been reported, both adjusted and unadjusted, and claims that have happened but not reported. The size of the loss reserve is relative to the type of coverage and experience. Some insurers, are even required to use projections and estimates to reflect the many contingencies that can affect loss reserves. Health insurance companies, for example, estimate claims that might occur after the policy expires. Worker compensation insurers budget on-going litigation. And life insurers generally use discount factors to reflect the time value of money and changing mortality concerning policies of potentially long duration. Insurance companies are constantly modifying their loss reserves to meet minimum regulatory requirements yet not exceed IRS guidelines for maximum deductibility. A high level of reserves also depresses profit which highly concerns shareholders.

Policy reserves are used primarily by life insurers to insure that policy obligations will be available when they are due. ***Policy reserves are measured*** by calculating net premiums received over the life of the policy (total premiums received less expenses) and the assumed interest that will help build cash value to pay death benefits. Mortality rates and reserve requirements change over the space of time which permit these figures to be modified. Policy reserves are usually grouped by block of business. In other words, policies issued in the same year, with similar face amounts, interest assumptions, age and risk level of insured. Uniformity makes it easier to group and calculate policy reserves. Over the years, the size of the policy reserves builds until the mortality cost for the particular block of business is covered. Then, the holding of reserves decreases until reaching zero when final claims are paid.

Specific A.M. Best formulas to calculate surplus and reserves include the following:

CASUALTY COMPANIES

Non-Investment Grade Bonds to Policyholders' Surplus : This test is vastly more popular due to the junk bond rush of the late 1980's. This ratio measure's a company's exposure to non-investment grade bonds as percentage of policyholder's surplus. Typically, bonds rated less than BBB are consider non-investment grade. The normal range for companies is from 0 percent to 10 percent. Above 10 percent is considered risky.

Loss Reserves to Policyholder Surplus : This ratio measures the potential impact that deficiencies in loss reserves have against surplus. The higher the ratio, the more reserves should be scrutinized. Casualty companies typically score from 50 percent to 150 percent.

Development Reserves to Policyholder Surplus : This reflects the change in loss reserve, as a percentage of surplus, from one period to another. The normal range is from 0 percent to 25 percent.

Developed Reserves to Net Premiums Earned : This test measures whether or not a company's loss reserves are keeping pace with premium growth. For the industry as a whole, the ratio is rising.

LIFE COMPANIES

Non-Investment Grade Bonds to Capital Surplus For purposes of this test, Class three bonds are considered below investment grade. The usual range for this category is 20 percent to 70 percent.

Mortgages & Real Estate to Capital & Surplus : The usual range for this test is 150 percent to 350 percent.

Delinquent & Foreclosed Mortgages to Capital & Surplus : Delinquent mortgages are those over three months past due. Normal operating ranges for this test are between 5 percent and 35 percent.

Affiliated Investments To Capital & Surplus : A ratio higher than 35 percent is considered risky.

WHO INSURANCE COMPANIES OWE

If there is anything the industry can learn from recent insurer liquidations it is that financial statements can be misleading. As we have just discovered, a company's earnings and surplus can appear to look good even when insurance sales are poor. Capital contributions or the sale of investments can easily make the bottom line seem profitable. Now, another factor must be considered -- who insurer's owe -- ***leverage***. In the insurance industry, leverage is typically incurred through the process of reinsurance. Insurers often find it necessary or at least advantageous to reinsure risks that they insure. For the most part, reinsurance remains as negotiated contracts between a reinsurer and the ceding company (original insurer). Reinsurance is important in that it contributes strength to an insurer by taking over part of its financial burden. This added strength, however, does not come without a price tag. The high cost of reinsurance and the safety and strength of the reinsurers themselves are now issues of concern to regulators and the industry.

Reinsurance plays a particularly vital role in the support of new companies and new policies. For new insurance companies, reinsurance is necessary to "selling" financial stability. After all, who wants to do business with a new company with no track record. Put a large established company guaranteeing the claims against the new company, however, and customers are more easily convinced. Leverage, or reinsurance, is also needed by many established companies who have had big spurts in business. A specific problem that all insurers have is the need to bolster their surplus during high volume periods. This is particularly troublesome during the first policy year. Accounting valuation of the policy and high costs to issue the policy (commissions, etc) in the first policy year post a loss and a reduction in company surplus. A strain on surplus can create problems with regulators and lenders, so insurers go to great lengths to "shore up" their surplus from first year losses. In some cases this is accomplished using additional capital contributions, but more often, the company will buy surplus relief reinsurance. This has the same affect to the balance sheet as adding capital and surplus is not reduced. In the process, however, a liability to the reinsurer is created. One test to determine if the amount of leverage is within accepted norms is as follows:

Ceded Reinsurance Leverage : This test measures a company's dependence on reinsurer stability. It is the ratio of reinsurance premiums ceded plus net reinsurance balances owed to policyholders surplus. The normal range for this test is from 0.5 to 1.3. Companies with higher ratios are considered to be too dependent on reinsurers.

REASONS WHY INSURANCE COMPANIES FAIL

Whenever a major financial institution is known to be underperforming or worse, "seized" by a regulator, there are accusations leveled about how and why this could happen. Investigations first seem to focus on "who" was at fault and the many sorted details on innocent customers who will be affected. Almost always, someone is next presenting a case on the "incompetence" of regulators, the greedy industry without compassion for its customers and some kind of comparison on how this same kind of problem happened somewhere else with devastating results. That is why, the current problems in the insurance industry are compared, ad nauseam, to recent calamities in the savings and loan industry. Some have gone so far as to label the insurance industry a savings and loan debacle waiting to happen. Regulators of both industries are being chastised for their lack of controls and need for faster response and early warning systems to alert the consumer.

Lack of Confidence

No one could say that these charges are entirely false. Every industry has its rogues and less than ethical players. What is often forgotten, however, is the fact that consumers create many of their own problems by choosing to ignore risks, even when they are told (or supposed to know) what could go wrong. It was fairly common knowledge, for example, that Executive Life was able to pay higher rates on annuities because they invested in higher risk investments. Basic economics tell us that the demand for a product or service is a "derived demand" -- derived, that is from the customers demand for those goods and services. Clients for Executive Life demanded higher rates. This does not excuse any alleged wrongdoing that may have been perpetrated by Executive Life, but policyholders who want higher than market returns should share in the risk of loss. Another interesting point about consumers is their sometimes unrealistic expectations. What consumers expect and anticipate may be the very thing that creates the problem. For example, when bond rating agencies dropped the portfolio ratio of Mutual Benefit Life, policyholders anticipated a faltering company. The eventual "run on the bank" actually created or accelerated the liquidation. Also, every casualty agent can attest to client demands for cheap coverage -- any coverage -- to meet some licensing or contract requirement. When something goes wrong and a non-admitted insurer is not capable of fulfilling its promises, one can only imagine how these clients will steam over the incompetence and lack of due care exercised by the agent.

Free Market Failures

Sometimes, the reason companies or insurers fail can only be explained as a consequence of free-market forces. They result in cases where large survives small, a new concept makes an old one unattractive, an unexpected event is just too large to recoup losses, lower prices prevail over benefits, higher interest rates win over lower rates or the economic climate is simply not conducive to making a profit. It is suggested that a combination of ALL these factors are responsible for reasons why some insurance companies fail in a free market.

Slim Profits

Declining profits are still another explanation for insurance failures. Premium wars and unusual natural disasters have whittled profits in property-casualty companies to levels lower than most other industries, while risk remains high. Life insurers have suffered from thinning margins of profits and greater exposure to interest rate cycles. In severe situations, either of these problems could cause a company to operate below accepted levels or force a conservatorship.

Management Mistakes

In 1990, the Government Accounting Office compared the failures in the insurance industry with 20 of the largest savings and loan institution failures. Of the eleven root causes identified for the failures, ten were the same for both the insurance companies and the thrift institutions. These included multiple regulators and infrequent examinations, rapid growth in risky business areas, poor underwriting, extensive underpricing, excessive reinsurance or loan participations, ***bad management***, and inadequate loss reserves. Only time will tell if there were, indeed, intentional or negligent abuses in the insurance industry similar to those found in the savings and loan shake out. An ongoing investigation into insurance fraud is underway by the Justice Department and the Senate has held at least two different investigations of insurance fraud since 1990. Certainly, violations will be found, but it is not likely to be as widespread a problem as the savings and loan fiasco since insurance companies are, by design, better able to "pay" for their mistakes since they are financially diversified, more liquid and quite a bit larger (most insurance companies are national in scope). Critics will point out, however, that while these differences may be true, insurance companies DO NOT have any federal backing, such as Federal Deposit Insurance as a backup. This would suggest that a failure by an insurer could be a greater downside for policyholders -- especially if the state guaranty funds backing insurers failed to function as promised. A major discussion of state guaranty funds can be found in a later chapter.

The savings and loan debacle will probably outshine the "fallen angels" of the insurance industry for another reason -- people. Many prominent savings and loan executives took big falls in the thrift shakeout, including civil and criminal charges. The spotlight was intense and involved some of the nation's most prominent figures -- Charles Keating, Gerald Ford's son, etc. Similar actions are now being pursued against insurance executives without as much fanfare. As case in point is the suit by the State of New Jersey against former officers and

directors of failed Mutual Benefit Life. Charges allege negligence by these individuals that permitted Mutual Benefit to pursue shaky real estate investments and leveraged buyouts. Some of the investments, as charged, involved conflicts of interest for top officers who purportedly profited from the deals. A list of the parties named is like a Who's Who in America, including a U.S. Senator, a top official of American Express, the owner of a pro football team and more. A similar drama is being played out in a suit filed by the State of California regarding Executive Life. This action (Garamendi v. Carr, etal) names Fred Carr, several corporate offices, former auditors Deloitte & Touche, ratings services A.M. Best Co., Moody's and Standard & Poors. The liquidator may also sue the insurer's managing general agents and reinsurers who were believed to have inside information on mismanagement within the company.

Junk Bond Investments

The search for higher yields seemed to dominate investment manager thinking in the 1980's. In part, it was driven by consumer demands for higher earnings. At one time, for example, single premium deferred annuities were yielding as much as 14 and 15 percent (tax deferred). Then came single premium life, structured settlement annuities and guaranteed investment contracts (GIC's). Once a company offered high rates, others followed suit in an effort to remain competitive. In order to pay these higher rates, insurers needed to invest at higher rates. At about the same time, brokers like Drexel Burnham were heavily involved in funding major corporate takeovers and mergers. Insurance companies were the perfect entity to finance these transactions through the purchase of bonds. A single transaction, such as the 1986 Maxxom takeover of Pacific Lumber Company, could involve as much as $900 million. It wasn't until Michael Milken took a fall that bond issues such as these became a sore issue in the financial dealings of insurance companies. Companies with more than 20 percent invested "junk bonds" were under heavy criticism, by agents, regulators and consumers alike. Executive Life of New York and Executive Life of California were over 60 percent invested in junk issues. And, it took even longer for regulators to take action because for years, these bonds were held on the books at their purchase cost, not market value. So, insurer's financial statements still looked reasonable. In addition, regulators were not as harsh in classifying what is a "low grade" bond as were the rating services like Moody's and Standard and Poors.

In 1990, standards were laid down by the National Association of Insurance Commissioners ranking the quality of issues. A numeric ***classification*** is assigned to all ***bond holdings*** as follows: Class 1 (highest quality), Class 2 (high quality), Class 3 (medium quality), Class 4 (low quality), Class 5 (lower quality) and Class 6 (poor quality). Investment grade securities now may only qualify as Class 1 or Class 2 bonds. Classes 3 through 6 are categorized as non-investment grade or "junk" bonds. Obviously, companies that maintain a high concentration of non-investment grade bonds will be scrutinized more closely than in the past. Further, regulators and rating agencies alike are also giving attention to the types of investments made and the ability to "match" assets and liabilities (the concern is that where assets are not linked to liabilities, fluctuations in interest rates can negatively impact cashflow and surplus. With these precautions in place and with promise of stepped-up regulatory monitoring, a decline in non-investment grade securities has occurred during the early 1990's. Much of this through a "controlled liquidation" to help shore up and clean up insurer balance sheets. Industry wide holdings in 1993 were estimated at only 3.8 percent of invested assets compared to 7.2 percent in 1990.

Real Estate Investment Losses

Without a doubt, another contributor in the insurance insolvency war is real estate. Specifically, nonperforming and underperforming commercial real estate. Most insurer's hold over 90 percent of their real estate mortgages in commercial properties. It is the nature of these loans, not delinquencies that has caused problems. Delinquent real estate loans reached a peak of only 7 percent of the industry's total 1993 loan portfolio -- mostly commercial projects that started unwinding around 1990. ***Problems with insurer real estate and loans took root*** in purchases and loaning in the "oil patch" areas (before the oil industry buckled under) and the building boom of the 1980's. During this latter, banks and thrifts maintained their role as construction lenders while insurers competed more heavily in the "mini-perm" market. ***Mini-perms*** are loans of from five to seven years designed to fill the gap between construction financing and long-term financing. As longer, permanent loans became harder to get in the 1980's so grew the mini-perm market. And, as luck would have it, many of these same loans are coming due in the early 1990 recession at the same time that the demand for commercial space is down and the ability to refinance or replace these maturing loans is practically nonexistent. Specifically, this is the reason why public rating services have downgraded so many life insurers with large mortgage loan portfolios.

Concurrently, ***commercial property owners*** have encountered great ***difficulty*** in generating sufficient operating revenues, on the heels of major rental rate deals and other tenant concessions, to keep mortgage loans current. Thus, a rise in loan delinquencies has also occurred, again, mostly among office and commercial real estate.

To date, the ***effects of loan delinquencies*** on insurer balance sheets has been minimal since real estate owned and mortgages typically represents less than 3 percent of the industry's assets (about 19 percent for life companies). However, with the advent of new Risked Based Capital requirements, "***down rating***" by major services for insurers with large real estate portfolios and poor public perception about insurer real estate owned, the negative impact of delinquent real estate has intensified. The threat of "bad press" has prompted many insurers to "sell short" or ***restructure underperforming real estate and real estate loans*** -- sometimes prematurely -- to avoid rating write downs. Further, a company with slightly higher than normal mortgage delinquencies or an above average volume of real estate loans could now be subject to regulatory control or corrective action under new National Organization of Insurance Commissioners guidelines. Under these standards, regulators could force companies with a low ***risk capital base*** to raise capital and take other steps to avoid failures. In more severe cases, reserves for expected real estate losses could be mandated. Also, an insurer must calculate whether capital deficiencies under the NAIC rules, based on the mix of their real estate portfolios and real estate owned. When deficiencies are present, the insurer may be forced to consider changing its asset mix -- selling nonperforming real estate in exchange for bonds. As of 1993, nonperforming real estate mortgages has declined from a peak of about 8 percent in 1992 to just under 6 percent. However, this does NOT account for money raised through ***guaranteed investment contracts*** which are essentially mortgage backed bonds. A major inventory of these contracts will be maturing in the mid 1990's which will exert added pressure for performance. Reductions of nonperforming mortgages have also been attained by restructuring or refinancing troubled loans or providing new loans for new buyers on foreclosed real estate. With a stroke of the pen, these new loans or newly structured loans are no longer nonperforming. Yet, the real estate tied to these loans is the same. Further, insurance companies may own problem real estate through partnerships. Again, this nonperformance is not reflected in Industry wide statistics. Another significant trend of the early 1990's is the ***"bulk-sale" of real estate owned***. An appetite for non-performing real estate developed as a result of the banking industry fallout. Agencies like the Resolution Trust Corporation found plenty of buyers for foreclosed real estate and underperforming mortgage loans. At a time when the Resolution Trust was running out of investor, insurance companies were in the mood or required to let go of some large, but less than spectacular real estate properties. Sales prices like $634 million (Travelers) and $1 billion (Prudential) have been commonplace. While some these properties were sold at somewhat competitive prices, the hardest financial pill to swallow was the time period between the default of payment and actual foreclosure. Liberal tort laws allowed owners lengthy bankruptcy protection which cost insurers dearly or forced them to restructure loans at the last minute. In many cases, insurers had to be involved and stand the cost for managing these properties until an agreement could be reached.

Not all of the "moves" to reduce nonperforming real estate have been accomplished voluntarily by insurers. Even before NAIC risked based capital ratios, insurers were feeling regulatory heat to restructure or move nonperforming loans off the books to avoid capital ***deficiencies or substantial write-downs under generally accepted accounting principles (GAAP)***. An insurer typically carries real estate assets at historical costs. Under GAAP guidelines, however, collateral received as a result of a foreclosure is returned to the insurer at its fair market value. Because commercial property values have declined so rapidly, fair market values on foreclosed properties could be substantially less than the historical value. This can result in substantial GAAP write-downs at foreclosure. Owning and managing foreclosed real estate can also drain an insurer resources. A decision must be made whether to continue holding the asset until the economy rebounds or risk further deterioration if the economy goes the other way. Holding on may also involve setting aside reserves under NAIC rules. Selling foreclosed real estate may also be difficult to accomplish in today's depressed market. With many other lenders and insurers selling nonperforming real estate, a deep discount may be required to unload a problem property. This can result in further write-downs from the value carried on the books. In either case, holding or selling depressed real estate, the process can adversely affect earnings, capital requirements, dividends and ratings. An option for an insurer may be to ***package multiple properties and mortgages as collateral for a new securities offering to raise new capital***. This will aid an insurers liquidity, but the original real estate asset or loan would remain on the books, perhaps at a deep discount. Again, the need for additional reserves exists and the condition still "muddies" the balance sheet. A more creative approach involves "spinning off" or selling problem real estate and loans to a new entity (created by the insurer). The new entity sells bonds or stock to the public to buy the problem assets. Since this is considered a sale, the asset gets off the books, the need for reserves can be eliminated and the insurer's balance sheet is cleaned up. This helps the company meet GAAP, statutory capital

requirements and improves the "rating picture". In addition, the real estate assets are, in a manner of speaking, retained to take advantage of any real estate turnaround. As with any strategy, there are pitfalls to the "spin-off" including deep discounts, the cash drain to start a new entity and the possibility that the transfer may be a taxable event.

By all standards, the handling of problem real estate and mortgage loans is part of doing business in today's insurance world. Realistically, this has been the cycle of real estate and most investing for as many years as insurers have been around. One must wonder, however, if the popularity of "***real estate bashing***" has promoted a wide scale purging of real estate assets beyond reason. Real estate has been a traditional sound and profitable investment for insurance companies since their inception. It has been the policy of insurance companies to invest in real estate for income and hold these assets to maturity. Therefore, the industry feels that only an assessment of how these assets perform over time is important -- not a temporary drop in book value reflecting some current market condition. While this may be a sound investment practice it is unfortunate that regulatory measures and rating standards related to real estate are so closely influenced by public perception of the moment.

Fortunately, and, for the meantime, most mortgage loan delinquencies and problem real estate have settled with the large insurers. Analysts do not expect this to create an industry crisis similar to the savings and loan debacle. Moreover, most insurers have substantial cushions against real estate losses and/or have raised new capital offsets.

Regulatory Guidelines

The outcry to limit insurer's holding of junk bonds and real estate has forced many companies to restructure their portfolios by ***divesting these assets***. In the case of bonds, a very low interest rate cycle during the early 1990's greatly favored the sale of bonds, and, in fact, created large capital gains for many companies to offset losses elsewhere. In the case of real estate and commercial loans, divesture has NOT been as easy considering difficult market conditions. In response, the rating agencies and regulators are fast developing new criteria to assess the ***ratio of junk bonds or high risk issues*** and less favored assets like real estate, common stocks and real estate owned by the insurer. Examples include the WAR (Weighted Asset Risk) Formula developed by Townsend and Schupp, Risked Based Capital and Bond Classification developed by the National Association of Insurance Commissioners. The details of these programs are best left to later sections, but the importance of these tools is that each analyzes insurer assets by breaking down the various levels of risk they present. In essence, B rated bonds are assigned a higher risk than AAA bonds. Using historical simulations, formulas such as these may have raised "red flags" years before the downfall of companies like Executive Life, First Capital Life, Fidelity Bankers Life and Mutual Benefit Life.

SOURCES & FACTORS OF AGENT DUE CARE

An agent is engaged by a client because he or she is an insurance professional. Clients should rightfully expect to be placed with financially reliable insurers, matched to appropriate insurance products which are accurately and completely presented by way of an illustration or financial plan. In accomplishing these tasks, it is hoped that at least a few of the following sources and considerations will have application and involve the agent in these areas of due care -- some of which are largely ignored by the agent population. If this is considered too time consuming, an agent would be advised to concentrate only on those companies where this information can be acquired. The story "behind" the numbers is often as important. This may involve some digging and use of sources outside rating services and insurance company literature.

QUALITATIVE CONSIDERATIONS

Agent Representations

Basic agency law demonstrates that agent liability can exist where the agent has offered a personal warranty. Providing clients with any methodologies or procedures used in evaluating companies, may be construed as a warranty in that the agent has "vouched" for a company or product. Written and oral declarations made by the agent are admissible evidence in this matter. Therefore, even though analysis is considered important to "agent

due care", a malpractice attorney may advise agents to conduct due diligence, document his or her findings for the file and use only published rating information or third-party testimonials to demonstrate the recommendation. Beyond this, the advice of an attorney to prepare a proper disclosure concerning the risks of using a specific carrier or the inability to guarantee ongoing solvency might be appropriate to mitigate any potential problems down the road.

In a similar vein, illustrations and quotes as sales tools have triggered agent liability. While projecting detailed client results over 20 or 30 years can be impressive and confirm a sale, they are also potential warranties of expected results which may subject agents to a shortfall dispute. The classic example is an annuity proposal which assumes a rate of interest of 10 percent. When interest rates drop to 6 percent, projections in the proposal are no longer valid. In addition, even though quotes show guaranteed results, a change in mortality tables or experience ratings could totally re-arrange an illustration or quote. An agent might be advised to run a range of illustrations and counsel clients on these potential changes which could effect ultimate policy results. Recent laws in some states now require the agent to highlight or bold the "guaranteed" portion of an illustration or proposal.

On-Going Monitoring of Companies

There are several recent court cases involving agents and insolvent insurance companies. In Higginbotham v. Greer, it is suggested that agents need to keep clients informed about significant changes in the financial condition of the company ***after the sale.*** Again, attorney's might advise that an agent conduct any and all on-going due diligence, document files and utilize published and third party testimonials to make a case for maintaining, switching or surrender of a policy.

Policy Replacement

Where an agent is recommending replacement of an existing policy due to deteriorating carrier finances, it is important to also evaluate factors of the client's health, condition of property, penalty charges that might be levied to surrender the original policy, tax considerations, pre-existing conditions that have already passed on the original policy must be started again on a new one, the incontestability provisions may have already expired on an old policy while a new one starts a new contestibility period and more.

In addition, agents must carefully consider any recommended move of client's coverage from a company rated "A" or better to a lesser rated carrier. Even if the intent was to provide superior coverage, the client's security position has technically downgraded. Agents might be advised to fully document files on why this recommendation was made.

Too Good To Be True

It is an old-age adage, but it has never taken on more meaning. Agents might be advised to at least be suspicious of a company offering a "better deal" than anyone else. It is common sense that something along the way will suffer as it did in the case of some life companies that invested in junk bonds and many casualty companies who participated in deep discount premium wars where expenses and claim costs at times exceeded income. This can only represent a degenerative financial condition for the insurer.

Also remember that insurance professionals, as salesmen, want to believe something is a better product or a better company. By their very nature salesmen often "get sold" as easy as some clients. It would be wise to be critical of all brochures and analysis distributed by a carrier which portray it to be the "best" or "safest".

Diversification

In the quest to satisfy solvency due care, perhaps a strategy of multiple-company coverage is the answer. For a client's life insurance needs, some combination of term, whole life, variable life or universal life may be employed to spread the risks among many different insurers and product lines. The variable life component could be diversified even more by using multiple asset purchases. On the casualty side, similar diversification might be employed between business and homeowners policies, worker's compensation, professional liability,

etc.

Conflicts of Interest

Agents receive a commission for their expertise in selecting a suitable product and company. The fact that the agent receives this commission back from the same company represents a definite conflict of interest. An ethical agent should disclose this fact in reference to the choice of the company selected. Where the commission is higher than normal, one might question the specific policy elements that will be affected (higher surrender or cancellation charges, etc) or considerations about the financial qualifications of the insurer and include these facts in any disclosure. An insurer recently placed in liquidation, for instance, had a known history of paying higher than prevailing commissions.

Basic Reinsurance

Reinsurance is an effective tool for spreading risk and expanding capacity in the insurance marketplace. The strength of the guarantees backing the primary policy, however, is only as strong as the financial strength of the reinsurer. Abuses have occurred where the levels of reinsurance have been too high, the quality poor and the controls nonexistent. Industry analysts suggest that the total amount of reinsurance should not exceed 0.5 to 1.3 times a companies surplus. Agents should also be concerned about foreign reinsurance since U.S. regulator control and jurisdiction is difficult. See how much of the foreign reinsurer's assets are held in the United States. Ask if the reinsurer has directly guaranteed the ceding company or using bank letters of credit for this purpose. These credit letters have not been effective guarantees in the past. Also, under terms of the ceding contracts, can the reinsurance be "retroceded" or assumed by another reinsurance company -- it is possible to have layers of reinsurance which could create difficult legal maneuvering during a liquidation. Does the ceding contract have a "cut-through" clause which allows the reinsurer to pay deficient policyowners or insureds direct, rather than to the liquidator? Is the insurer writing a significant amount of new business that may require costly amounts of first year reinsurance?

First-Year Reinsurance

The first year that an insurance policy goes on the "books", the insurance company suffers a loss. This is attributed to laws related to the accounting valuation of the policy and the high costs or expenses paid in the first year (commissions, etc). A loss to an insurer, is also reduces a company's surplus. A strain on surplus can create all kinds of problems with regulators and lenders, so insurance companies go to great lengths to shore up their surplus from the losses of first year policies. This may be accomplished by raising additional capital or through some form of financing. More often than not, however, an insurance company will simply call up the local reinsurance company and obtain surplus relief reinsurance. Once in place, surplus reinsurance provides the ceding company (the insurer who uses the reinsurance funds) with assets or reserve credits which improve the insurers earnings and surplus position. The major difference between using reinsurance to cover first year losses and a loan is how the transaction is reported. When an insurer obtains a loan, the accountant must record a liability. Reinsurance for surplus relief, however, is NOT considered a liability under statutory accounting because the repayment is tied to future profits of the policy or policies being reinsured. Collateral for the reinsurance, in essence, is future profits. Thus, reinsurers run substantial risks when the ceding company cannot pay. The fee or interest for providing the reinsurance is typically from 1 percent to 5 percent of the amount provided.

Regulators are well aware of reinsurance surplus relief practices. Over the years, they have introduced rules which attempted to minimize abuses. The 1992 Life and Health Reinsurance Agreements Model Regulation was adopted by the National Association of Insurance Commissioners for implementation starting in 1994. The National Association of Insurance Commissioners also adopted a 1988 regulation which reads as follows: " . . . If the reinsurance agreement is entered into for the principal purpose of providing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the unexpected potential liability to the ceding insurer remains basically unchanged".

Restructured Loans

What percent of an insurer's nonperforming or underperforming real estate projects have been "restructured" -- sold and self-financed to a new owner at favorable terms to eliminate a "drag" on surplus.

Size of Company

Statistically, fewer failures have hit companies with assets greater than $50 million. It is thought that larger companies have more diverse product lines, big sales forces, better management talent--in essence, they are better equipped to ride out financial cycles. In recent wide scale downgrading of insurers, A.M. Best seems to have favored significantly larger companies in the over $600 million category. However, another advisor feels that a small, well capitalized company can deliver as more or more solvency protection as a large one suffering from capital anemia.

Lines of Business

An agent may not have many choices over the company he writes, e.g., worker's comp coverage can only be secured with a carrier willing to write worker's comp. It has been suggested, however, that agents may consider evaluating multi-line companies to determine if one of the lines is weak enough to "down-drag" a profitable line. An example could be a life company that also writes health insurance as a direct line or business or by affiliation. If health carriers become threatened under a new national health care proposal, it could spell trouble for an insurer's health line which can affect ALL lines of business written. Of course, this is not to say that a multi-line carrier cannot be profitable and solvent.

State Admitted

Checking that an insurer is licensed or admitted to do business in the state at least assures that the company has met solvency and financial reporting standards. Most states offer toll free numbers for these inquiries. Some states will also divulge the rank of an insurer by the number of complaints per premium volume.

Mergers

Insurance ratings are sacred territory. A rating drop against Mutual Benefit Life triggered a run on that insurer which caused its conservatorship. This news and the overall crisis of confidence surrounding the insurance industry has prompted insurers to consider many options to shore up these ratings. One option is the merger. The combining of companies can be critical to retaining policyholders, attracting new customers and maintaining investment capital sources. Some experts believe that consolidations in the insurance industry will become more commonplace in the future. One source estimated that the current number of life insurance companies--estimated at 2,000--will merge down to an eventual 200 insurers by the year 2000.

Parent & Holding Company Affiliation

Who or what kind of company owns the insurer that is considered. Is the parent sufficiently solvent that it will not recruit or siphon funds from the insurer? In a like manner, does the insurer own an affiliate that may likely need capital infusion from the insurer? Has the agent's insurer recently created an affiliate and are the assets in this affiliate some of the non performing or underperforming investments of the original insurer? Is a merger in the offing that might mingle your client's A-rated company with a larger B+ company? In what partnerships or joint ventures does the insurer participate? Do these entities own problem real estate properties of the original insurer? Has the insurer invested in other insurance companies and have those companies, in turn, invested back in the original insurer or one of its affiliates?

Name recognition can go a long way in giving a client a high level of comfort. In the early 1980's, for example, Cal Farm Insurance, a B rated company, was proud to point out that it was owned by the California Farm Bureau, a 100 year old company. By the mid 1980's, however, Cal Farm Insurance was liquidated by the California Department of Insurance for overextending itself on financial guarantee bonds that it could not pay. Because the claimants were considered to be sophisticated investors, they received only 25 cents on the dollar

and forced to foreclose on the properties behind the financial guarantee bonds by themselves. The California Farm Bureau was not considered as a source to pay any deficiencies.

Other abuses have occurred with a slightly different twist. For example, Senate investigations have revealed that the failure of many insurers can be directly tied to the "milking" of these companies by a "non-insurance" parent. Further, not all abuses have been on the side of the parent. Insurance companies themselves have been known to tap huge sums of capital from their parents, commingle assets and devise elaborate schemes including sale and leaseback arrangements and the securitization of future revenues.

GAAP Bending (Generally Accepted Accounting Principles

Even before the National Association of Insurance Commissioners' risked based capital proposal, insurance companies were feeling regulatory heat for a fairly common practice involving underperforming and nonperforming real estate. In the past, insurance companies have simply carried the value of their real estate at its historical cost--no matter what! Yet, its makes sense that property that is not economically viable is worth less. This is especially true in the early 1990's where the fair market value of commercial property have decline rapidly and perhaps below historical cost. However, showing lower valuations would mean that insurers might develop capital deficiencies or incur substantial write downs. Either situation is hard to swallow. Now, new GAAP (Generally Accepted Accounting Principles) rules are being used by auditors which require foreclosed property or underperforming real estate to be valued at its current fair market value. Insurers must decide whether to continue holding an asset until the economy rebounds or risk further deterioration. Further, now that risked based capital is on their doorstep, holding nonperforming real estate may require companies to set aside additional reserves. In the past, if regulators started complaining, insurers would increase their capital, either from a parent company or through security offerings. While this would aid the insurer's liquidity, the original asset would remain on the books, perhaps at a deep discount. A more creative approach involves "spin offs" (below).

Asset Spin Off's

Insurer balance sheets can easily get out of whack if they hold underperforming or nonperforming real estate. As mentioned above, new GAAP write down rules would require a valuation of this real estate at its current fair market value, which may be extremely depressed. To help "clean-up" their balance sheets and possibly avoid strict risked based capital requirements, some insurers transfer or "spin off" the foreclosed or underperforming asset to a new entity which they create. This entity sells bonds or stock to the general public to buy the problem asset(s) from the insurer. Since this is considered a sale, the asset gets off the books. The need to set aside reserves and meet GAAP rules is eased. And, company ratings are maintained. In all fairness to insurers, what appears to be a deception is often a sound business strategy to "hold" an asset that is not performing today but is expected to rebound when the economy improves. So long as this can be accomplished and NOT hamper current operations, the insurer may be making a smart move since significant appreciation in the asset down the road could later improve the company's balance sheet by leaps and bounds. Also, "spin offs" are not without their risks. There is the cash drain of starting a new entity, the deep discount of the sale and the possibility of a taxable event.

Collateralized Mortgage Obligations & Derivatives

In the past, when insurance companies wanted higher investment yields they turned to real estate and non-investment grade bonds. New risked based capital rules, however, make these types of investments difficult to "book". Insurers, however, have found ways to still participate in the yield of these investments without owning the actual product--they are called collateralized mortgages and derivatives. In simplest terms, ***collateralized mortgage obligations and derivative*** are like stock certificates backed by mortgages or bonds. The "slant", however, is that they are owned by a trust and then sliced into pieces of various maturities consisting of principal and interest payments. They are also further divided into issue classes called "tranches". The first principal payment, for example, would go to tranche 1; and so on. Tranch 2 might be "interest only" strips. Investors will jockey for particular tranches based on their rate of interest, their individual requirements and their outlook on where interest rates are going. Investments in the junior tranches offer significant yields, yet come

with the risk of prepayment. Senior tranches generally minimize market risks since cash flows are more predictable. Suffice to say, CMO's and derivatives are highly sophisticated, higher risk investments that require sophisticated monitoring and significant hedging capability.

Tax Angles

Regulators and accounting practices appear to be getting stiffer for insurance companies. One thing the industry can still count on is certain tax advantages. In essence, losses from insurance operations can be used to lower taxes elsewhere (such as capital gains from the sale of bonds or real estate). Multi line companies, can use losses from property and casualty claims to offset profits from health and life insurance divisions. And, surprisingly, companies can sometime take a percentage of their losses as a "tax credit" and write it up as an asset on the theory that the tax credit will be worth something to them in a profitable year. This practice is acceptable as long as the company can show beyond all doubt that it will be able to use the credit sometime in the future. Critics, feel that the tax credits are actually "paper profits" which can hardly be used to pay claims. In periods where insurers are posting major losses--such as the mid 1980's and early 1990's--tax credits such as these may account for up to 70 percent of a firms operating income.

How much of an insurer's operating income consists of tax credits generated from claim losses or guaranty fund? How much of an insurer's operating income comes from capital gains earned from the "bulk sale" of longstanding bonds or real estate?

Restructuring Loans & Partnership Deals

The last thing an insurer want's of the books is foreclosed or underperforming real estate. New risked based capital and GAAP accounting standards deal harshly with this type of asset. This is exactly the type of asset, however, that many insurers are "knee-deep" in handling, especially on the heels of big real estate purchases in the late 1980's with money raised from guaranteed investment contracts (GIC's). A way to alleviate the underperforming properties is to convert them to new loans--essentially refinance them for the owners at new, easier to handle payments--or restructure the existing loans by temporarily dropping the payment. It is also interesting to note that many insurance companies own problem properties that regulators do not see because they are owned through a partnership between the insurer and a joint venture entity.

Liability Adjustments

Reducing liabilities is always desirable since surplus will be enhanced. Some companies make small adjustments to their liabilities to make them appear smaller. One such adjustment can be accomplished by deducting the surrender charges policyholders would pay if they cashed their policies in early. Companies have been known to take this deduction knowing full well that NOT all policyholders will require early withdrawals or full surrenders of their policies. Some insurance regulators still allow this accounting method.

Cash/Stock Swaps

When things get tight, some insurance companies invest in each other or among their subsidiaries using a system of complicated cash and stock swaps. Not too long, Charter Life was entering bankruptcy. Working together with Capitol Life and Providence Life, Charter paid $37.5 million in cash to Providence for preferred stock issued by Capitol Life. Capitol Life paid $35 million in cash to Charter for newly issued Charter preferred stock. Capitol Life, in turn, transferred the Charter preferred stock to another Providence subsidiary which, in effect, absorbed a $28.6 million loss on the stock so that Capitol Life wouldn't be effected by Charter's bankruptcy law filing. Capitol Life continued to pay dividends on its preferred stock held by Charter's insurance unit.

Selling Loss Reserves

Under pressure to improve earnings insurers have used the somewhat questionable technique of "selling loss

reserves". How does an insurer sell losses? Generally, it involves paying another insurer now for its promise to pay certain claims in the future. A few years back, for example, Aetna passed the liability for an estimated $80 million of unpaid medical malpractice insurance claims to Fireman's Fund Insurance Co in return for an agreement to eventually pay those claims. Fireman's received a steep discount on the claims for a profit of approximately $22 million. Aetna relieved itself of $80 million in liability. Reinsurers are also big buyers of loss reserves. Critics say its an accounting gimmick. Industry spokesmen claim it is merely a method of transferring risk.

Assumption Reinsurance

Reinsurers assume the risk(s) of a ceded company on a regular basis. Congress, however, is very disturbed that this practice is continuing without policyholder knowledge--assumption reinsurance. Put simply, insurers seeking to deploy their assets more profitably, "jettison" blocks of policies to reinsurers. Critics believe that policyholders should be advised in advance when a reinsurer is considered.

QUANTITATIVE CONSIDERATIONS

Using the Rating Services

There are many different ways to develop rules of thumb using rating service information. One approach might be to delineate a "range of acceptability" among specific rating companies. For example, if an agent were ultra conservative, he or she may set a rule that all his chosen companies must be in the top two categories of the four major rating services:

A+ + or A+ from A.M. Best
AAA or AA+ from Standard & Poors
Aaa or Aa1 from Moody's
AAA or AA+ form Duff & Phelps

A slightly less rigid approach would establish a minimum rating requirement of NOT lower than the fourth category from any of the major companies:

A- from A.M. best
AA- from Standard & Poors
Aa3 from Moody's
AA- from Duff & Phelps

Or perhaps, an agent might decide that a company must only meet one or more requirements from three of the four major rating companies. A word of caution is in order regarding ratings. Agents who do not find a company rated must investigate the reason. If the company has not been around long enough to rate, it may be better to avoid doing business unless a reinsurance contract with respectable contract is in force. Or, it may be necessary to ask the insurer or the rating company is a rating was issued but suppressed from being published. Currently, only Standard & Poors and Duff & Phelps will suppress a rating.

Variations in Ratings

One major rating agency suggests a way to determine if an insurer is running into difficulty is to monitor several ratings. If the ratings vary widely, this should send a signal that there are other factors of concern regarding the insurer. A recent example is United Pacific Life. In 1992 they were rated A-plus by Duff and Phelps, BBB by Standard & Poors and Ba-1 by Moody's.

Commisioner's Analysis

In the mid 1980's, then Insurance Commissioner of California, Bruce Bunner, offered agents a unique opportunity. He proposed ***five financial formulas*** producers could use themselves to test for carrier solvency.

In his presentation, through a monthly newsletter distributed to all California agents, Bunner noted that agents and brokers are not expected to be experts in the financial analysis. "Nevertheless, a producer does have a moral response", said Bunner, "to perform reasonable due diligence procedures with respect to the financial credibility of insurance companies being used to underwrite clients' risks. Bunner feels that financial ratios in and of themselves are not a panacea. They can, nevertheless, serve as guideposts to identify positive and negative financial trends and the comparative health and stability of a company within the industry. Further, "when the evidence clearly indicates that a company's financial condition is deteriorating, too many agents and brokers continue to place their customer's risk with the same company. When price alone is the only marketing consideration and the producer disregards emerging negative financial signals, the agent is doing an extreme disservice to his client, and as such, must morally share some culpability with company management when and ensuing financial debacle occurs."

Bunner's five ratios are simple to calculate and the necessary company financial data is readily available to the public in the annual statements on file at each state's department of insurance. The suggested formulas are: Gross premiums written to surplus; Two Year operating ratio; Surplus to admitted assets; Loss and expense reserves to surplus; and, The acid test.

Gross Premiums Written to Surplus: This is a variation on the National Association of Insurance Commissioner's IRIS test ratio (Insurance Regulatory Information System) which compares net premiums written to surplus. The National Association of Insurance Commissioner's IRIS test guideline considers a result of 3 to 1 as acceptable. Bunner feels ***2.5 to 1 as preferable***. Further, he believes that the IRIS test ratio should be expanded to compare gross premiums written to surplus rather than net premiums written to surplus. Gross premiums written in excess of 4 to 1 surplus should be considered unacceptable. Further, Bunner feels that the relationship of gross written premiums to surplus is more important because the National Association of Insurance Commissioners IRIS test fails to consider the effect of disproportionate reinsurance activity. Reinsurance transactions, therefore, can grossly distort results. As an example, an admitted insurance carrier domiciled outside the state was writing in excess of 20 to 1 surplus on gross premium written basis. On a net premium written basis, their ratio was approximately 3 to 1. Bunner requested the company either reduce its gross writings or voluntarily leave the state. The company chose to ignore the request and was eventually issued a cease and desist order. This example is an extreme case. However, evaluating this company on a gross premiums written basis did uncover that the company had some problems. To account for reinsurance activity, Bunner suggests that a ratio of 4 to 1 for gross premiums written to surplus allows for up to 25 percent reinsurance premium credit to achieve the 3 to 1 National Association of Insurance Commissioner ratio benchmark. If a company has to reinsure more than 25 percent of its direct premium business, Bunner, suggests an agent ask why, and then verify the financial security of the applicable reinsurance company or companies. "I would question closely", says Bunner, "companies that are in effect using reinsurance to broker significant amounts of direct business (25 percent or more of direct premiums) and, particularly if the direct business is being channeled to the non admitted market.

Two Year Operating Ratio : The two year operating ratio is an IRIS test that is basically an expansion of the combined loss and expense ratio where the ratio of the investment income to premiums earned is deducted from the combined ratio. Using financial figures for two years helps to level possible aberrations. Bunner says, "we traditionally have expected the two year operating ratio to be a result of ***100 or less***. A result in excess of 100 suggests that the company is not achieving an underwriting profit, but relying on investment income to offset underwriting losses and to achieve a reasonable return on equity". A quick calculation that can be done on a quarterly basis to achieve the same conclusion is to compare net income (exclusive of realized gains and losses) to prior years surplus. A result of less than 10 percent generally may be indicative of potential problems. A return on statutory equity of 10 percent or less hardly justifies the opportunity cost of the company's investment in statutory surplus. If the stockholder(s) are not willing to insist on an adequate return on equity, you may want to make some further inquiries. For both these tests, realized investment gains and losses should be excluded from investment income. This is a modification of the IRIS test which Bunner believes is appropriate because such gains and losses are non-recurring transactions and largely discretionary. From time to time, companies have been known to selectively sell appreciated assets to improve the appearance of operating results.

Surplus to Admitted Assets : Surplus to admitted assets ***generally exceed 25 percent*** for most insurance companies. A ratio of less than 20 percent for an individual insurance company should be consider questionable.

According to Bunner, "surplus provides a cushion for absorbing potential above-average losses". As discussed in the next section, deficiency in loss reserves usually carries over into higher multiples when related to surplus. If the company under evaluation is a member of a holding company system and fails this surplus ratio, Bunner suggests an agent should not be dissuaded by any arguments from management that the company's surplus is reinforced by the adequacy of the surplus of the parent or affiliated companies. Bunner states, "I strongly believe that every company granted a charter should be financially independent and its economic viability should NOT be dependent on other related entities."

Reserves to Surplus : The ratio of loss and loss expense reserves to surplus is not an IRIS test. However, Bunner thinks the ratio deserves more consideration by the National Association of Insurance Commissioners because of the extreme leveraging that is becoming more common in the insurance industry. It would be preferable if this ratio could also be calculated on a gross basis (before reinsurance) rather than on a net basis (after reinsurance). The problem company discussed earlier, for example, had a ratio of gross case basis reserves to surplus of 16 to 1 and most of its loss reserves were ceded to non-admitted insurers. If gross reserves were included, the ratio would increase to 32 to 1 or more. This degree of leverage is not prudent despite the adequacy of the security of any reinsurance. Bunner believes that a net loss and loss expenses reserves to surplus ***should not exceed 3 to 1***.

The Acid Test : This is Bunner's own formula for a quickly evaluating company liquidity or ascertain what he refers to as "hard surplus". Obviously, the formula can be refined but it does adjust for some of the weaknesses of statutory accounting. For this test, subtract from surplus the home office building(s), computer equipment, and any non-insurance receivables and other non-insurance assets that are reported as admitted assets by the company. This adjustment separates from surplus that part of surplus which is basically applicable to the operating assets of the company. From this adjusted surplus amount subtract any affiliated investments and advances; unrealized losses on investments in bonds and preferred stocks; and any contribution certificates, surplus notes and subordinated debentures; and add back the surplus appropriation for accumulated excess Schedule P reserves. The adjustment for affiliated investments and advances is to remove from surplus the effect of any pyramiding of assets which in extreme situations often contributes to insurer solvency. Unrealized losses on bonds and preferred stocks are typically disclosed in report supplements included with a company's annual statement on file at state insurance departments. Bunner is of the school that all investments held by an insurer should be reported at their current value. "The current accounting model", he says, "using amortized costs for fixed yield securities is too forgiving to company management. Statutory accounting obscures the effect of lost investment opportunities and encourages investment decisions (particularly investment hold or sell decisions) to be driving by accounting rather than economic conditions. Once all the adjustments above have been made, ***a surplus of LESS than zero, suggests that the company may have liquidity problems or be over leveraged.***

In closing, Bunner suggests that the failure of any one or more than one of these tests is not necessarily indicative of a company financial problem. Further, these tests do not adequately consider some complex financial issues associated with reinsurance, security of letters of credits, off balance sheet commitments and issues related to specialty companies writing insurance products as earthquake, professional malpractice, financial guarantee bonds and so forth. However, prolonged failure of any of these tests might suggest that company management is choosing to operate outside the boundaries of sound financial guidelines and should be suspect. As such, the producer agent should not be reluctant to demand satisfactory answers from the management of the insurance company. Bunner states, "some agents and brokers too often compromise themselves and their clients by accepting unrealistic insurance rates from marginal insurers to the exclusion of financial soundness and prudent management. Time and time again we have learned that this scenario will ultimately prove to be a disservice to the producer, the client and our industry at large."

An Author's Advice

The author of a popular selling book on investing offers some words of caution concerning annuity investment companies. He believes an agent should "bail out" his client if the insurer involved has been rated downward more than once within a one year period. He prefers a threshold rating of AA or Aa (Standard & Poors & Moody's) to stay involved with a company. Favorite ratios to analyze involves capital cushion. -- divide the company's statutory surplus (capital) by its assets. The more capital the better with an average industry ratio of 7 percent. Avoid high concentrations of junk bonds, repossessed real estate and nonperforming real estate

mortgages. When the combination of these exceed two or more times the company's capital be careful. Finally, always be suspicious of a company that offers a much better deal than its competitors.

Townsend & Schupp WAR Ratios

Townsend & Schupp (Hartford, Conn) is an investment banking and credit research firm specializing in the insurance industry. The company garnered the spotlight when it released its WAR (Weighted Asset Risk) Ratios in 1990. The study produced an outcry from four major insurers--Executive Life of California, Executive Life of New York, First Capital Life and Fidelity Bankers Life--who refuted the notion that their investment mix, using high ratios of junk bonds, represented a high risk. Less than one year later, all four companies were in conservatorship.

Although agents might attempt his own WAR ratio, it is only one aspect of how Townsend & Schupp analyses insurer safety. In WAR ratio analysis, assets are assigned risk factors (expected losses) for all classes, except mortgages and real estate where default and loss ratios are quantified based on interviews with major insurers. Risk factors are delineated by the following classes:

WAR RATIO EXPECTED LOSS FACTORS

Asset Class	Risk Factor
Bonds Rated AAA, AA, A	0.5%
Bonds Rated BBB	1.0%
Bonds Rated BB	2.5% Bonds Rated B 5.0%
Bonds Rated Lower	10.0%
Stocks / Preferred	2.5%
Stocks / Common	25.0%
Mortgage Loans/Current	5.0%
Mortgage Loans/Delinquent	20.0%
Real Estate Company Owned	5.0%
Real Estate Good Standing	5.0%
Real Estate Foreclosed	20.0%
Other Invested Assets	10.0%

Townsend & Schupp apply these risk factors to actual insurer investments and arrive at an aggregate total which is divided by the sum of composite surplus--statutory surplus PLUS MSVR (mandatory securities valuation reserve) PLUS voluntary loss reserves. The lower the WAR ratio the better a company's ability to recover or cover a liquidity crunch. A recent survey by Townsend & Schupp of 130 insurance companies found an average "expected loss" or WAR ratio of 40 percent of composite surplus. Top companies rate in the under 20 percent range while a few dangerously exceed 100 percent.

ANALYSIS SOURCES

A.M.Best Company
Ambest Road, Oldwick, NJ 08858
(908) 439-2200

Bestline 900 (automated current rating--$2.50 per minute) (900) 420-0400 / Key in AMB # from Bests Insurance Reports
Best's Insurance Reports
Best's Key Rating Guide
Best's Advance Company Records
Best's Aggregates & Averages
Best's Review Magazine
Best's Insurance Management Reports
Best's Agents Guide
Best's ESP (Electronic Statement Preparation)
Best's Retirement Income Guide
Best's Market Guide (Insurer Portfolios)

Best's Reproductions (Annual Statements)
Best's Underwriting Guide
Best's Underwriting Newsletter

Annuity Review Board
3835 North 32nd Street, Suite 6, Phoenix, AZ 85018
(602) 953-0599

Provides detailed financial information on well-known insurers and reviews policy provisions for individual annuity policies.

Duff & Phelps
55 East Monroe St, Chicago, IL 60603 / (312) 368-3157

"Insurance Company Claims Paying Ability Rating Guide" / Quarterly report on financial findings and ratings.

"Rating Guide" / Monthly claims paying ability

The Insurance Forum
Joseph Belth PO Box 245, Ellettsville, IN 47429

Publishes a "watch list" of underperforming companies based on IRIS (Insurance Regulatory Information System) statistics.

Journal of American Society of CLU & ChFC
270 S. Bryn Mawr Ave, Bryn Mawr, PA 19010 (215) 526-2524

Bimonthly publication on current issues

Money Magazine
Insurer Safety Watch / Major downgrades / Various issues

Moody's Investor Services
99 Church Street, New York, NY 10007 / (212) 553-1658

Insurance Rating Desk / 212-553-0377

"Moody's Life Insurance Credit Report" / Quarterly handbook with detailed reports on companies, special comments on industry issues, "flash reports" of rating actions and access to analysts and briefings.

Moody's Quarterly "Life Insurance Handbook" / Gives ratings, explains rationale and executive summaries.

National Association of Insurance Commissioners
120 W. 12th Street, Suite 1100, Kansas City, MO 64105

(816)842-3600

National Insurance Consumer Organization
121 N. Payne St, Alexandria, VA 22314

Consumer oriented manuals and advice concerning insurance products and insurance companies.

Standard & Poor's
25 Broadway, New York, NY 10004

Insurance Rating Desk / 212-208-1527

"Standard & Poors Insurance Book" / In-depth reports on each rated insurer including charts and graphs

"Standard & Poors Insurance Digest" / Quarterly publications containing the company's letter rating and basic rationale.

"Standard & Poor's Insurer Rating List" / A monthly list of insurers and their letter rating.

"Standard & Poors Insurer Solvency Rating" / Qualified solvency and claims-paying ratings for 1,600 insurers.

"Standard & Poors Select Reports" / Four-page reports excerpted from S&P's Insurance Book.

State Insurance Departments
Annual reports for each company filed with the state are public record. In most cities where reports are kept, a private "copy service" will go to the insurance department, copy specific reports and mail them to you for a fee.

Townsend & Schupp
100 Wells Street, Suite 802, Hartford, Conn 06103 / (203) 522-2214

Detailed and personalized quantitative analysis and comparisons of life insurance companies using proprietory ratios, e.g., Townsend & Schupp WAR Ratio, etc. Some services allow direct telephone access to top T&S analysts.

Weiss Research
2200 N. Florida Mango Rd, West Palm Beach, FL 33409 / (800) 289-9222

"Letter Grade" / Available by phone for about $15

"Personal Safety Brief" / One page analysis for about $25.

"Insurance Safety Directory" / Quarterly findings for life and health companies.

Weiss is also one of the few rating agencies to rank the nation's 72 Blue Cross and Blue Shield plans.

UPDATE / life & health

TAXPAYER RELIEF ACT OF 1997

Signed on August 5, 1997, this new tax legislation encompasses broad sweeping measures in the following areas:

CAPITAL GAINS

An individual's maximum tax rate on net capital gains has been reduced from 28% to 20% (gains currently taxed at 15% will be taxed at 10%). The holding period necessary to achieve long-term status has been raised form 12 months to 18 months for sales after 7/26/97.

Residence sales

Gains of up to $250,000 ($500,000 if married and filing jointly) from the sale of a personal residence (after 5/6/97) are now excluded from federal tax.

Traditional Ira's

Current income limits for deductible IRA's will be raised beginning at $50,000 for marrieds ($30,000 individuals) in 1998 and increasing to $80,000 in 2007 ($50,000 for singles by 2005). IRA contributions will be phased out for taxpayers with Adjusted Gross Income (AGI) between $150,000 and $160,000 beginning 12/31/97.

Roth ira's

The new law creates a "back-loaded" IRA called the ROTH IRA. Contributions would not be deductible but distributions, if certain requirements are met, will be tax free. Qualified distributions included those distributions made after five years from the date the taxpayer first contributed to the Roth IRA. Distributions will not be included in gross income or subject to the additional tax on early withdrawals.

Education ira's

Amounts distributed from Education IRA's to cover higher education expenses of an eligible student will be excluded from gross income and the 10% early withdrawal does not apply. Annual contributions to an Education IRA per beneficiary are limited to $500 but is phased out for taxpayers with modified AGI between $150,000 to $160,000 for marrieds and $95,000 to $110,000 for singles.

Estate and gift tax unified credit

Effective 12/31/97 the basic individual estate and gift tax credit, currently at $192,800 wil be increased annually or biannually until it reaches $345,000 in 2006. This allows tax-free estates and gifts, exclusive of the marital deduction, to expand from their current levels of $600,000 to $1 million by 2006. Family businesses and farmers have an adidtional exemption amount above the current $600,000 taking the sheltered total to $1.3 million.

Annual gift exclusion

The $10,000 each person may gift annually to any other person without incurring gift tax will not have annual cost-of-living adjustments for gifts made after 12/31/98.

CHARITABLE TRUSTS

Limits on income distributions from CRTs are now set at 50% of the value of the trust and the charity's initial interest in the trust must be at least 10% of the original trust value.

Health Insurance Portability and Accountability Act of 1996 (HIPPA) *(HR 3103)*

HIPPA and **The Small Business Job Protection Act of 1996** ***(HR 3448)*** were signed into law on August 21, 1996. HIPAA generally covers health care plans with at least two participants who are active employees of single-employers, multi-employers, and collectively bargained units. Generally, the statute allows individuals who leave their employers to keep health care coverage or obtain new coverage, regardless of any pre-existing medical conditions. In addition, these bills introduce ***Medical Savings Accounts (MSAs)***, the phase-in of health insurance deuctions for the self-employed and made certain "tax-qualified" ***Long Term Care Policies*** deductible.

HEALTH CARE PORTABILITY

Under HIPAA, the maximum pre-existing condition exclusion period that any group health plan or insurer may require for new enrollees is 12 months from the enrollment date or exclusion. This period is increased to 18 months for late enrollees. Group health plans and their insurers must reduce this pre-existing condition limitation period by the individual's aggregate period of previous health insurance coverage. The pre-existing condition exclusion period is reduced by one day for each day of an individual's creditable coverage under a former health plan. As a result, neither group health plans nor their insurers will be able to deny coverage or apply pre-existing condition exclusions to individuals who had prior health coverage for at least 12 months. The credit for prior coverage is lost, however, if an individual went 63 or more days without coverage.

Each employer or health care issuer is responsible for providing to terminating employees, their spouses, and dependents certificates evidencing their period of health coverage under that employer's health plan. Certificates of creditable coverage will have to be provided automatically upon certain triggering events. These events include when an individual loses coverage under the employer's health plan, when an individual becomes covered under COBRA, and when an individual is no longer covered under COBRA. In addition, certificates will also have to be provided to any former participant upon request within 24 months after coverage ceases.

HIPAA also expanded rights under COBRA for certain individuals. Under the new law, the definition of a qualified beneficiary has been amended to include a child born or adopted during the COBRA continuation period. This law also requires that qualified beneficiaries be permitted to change coverage status from individual to family upon the birth or adoption of a child under the same terms as are applicable to active employees.

In addition, the new law expands the scope of the extension applicable to disabled employees and their dependents. Under the former law, an employee and his or her dependent could extend their COBRA coverage for an additional period of 11 months if they became disabled at the time of the qualifying event. The new law permits use of this extension for any employees and their dependents who become disabled during the first 60 days of the 18-month COBRA coverage period.

These changes have been effective since January 1, 1997 and notice of these changes was to have been given to all COBRA beneficiaries no later than November 1, 1996. Employers who have not taken steps to comply with these changes should take immediate steps to do so.

Group health plans and insurers that fail to meet the requirements of the new law may be assessed a penalty of $100 for each day for each individual affected by the failure. Moreover, there is a minimum penalty tax where the failure is discovered after a notice of examination. This tax is equal to the lesser of $2,500 or the amount that would be determined under the $100 per day rule. Significantly, the $2,500 is increased to $15,000 if the violations for any year are more than de minimis. Under any circumstances, the maximum penalty is $500,000. Because of the potential liability involved, plan sponsors should take appropriate measures to amend group health plan summary plan descriptions and to assure the proper establishment and implementation of procedures for tracking and certifying periods of creditable coverage.

MEDICAL SAVINGS ACCOUNTS

For a test period, 1997 through 2001, the bill allow 750,000 taxpayers to apply for a special MSA deduction plan. To qualify, a participant must have a high dedutible health plan with a deductible of **at least** $3,000 but no more than $4,500. Contributions to the MSA are limited to 75% of the deductible amount (65% of a maxmimum $2,250 deductible for individuals).

HEALTH INSURANCE DEDUCTIONS

The new law phases the deductibility of health insurance premiums for the self employed from 40% in 1997 to 100% in the year 2007. It should be noted that ONLY health insurance premiums are deductible.

CALIFORNIA REGULATIONS

ab 8 / health

Expands the definition of "small employers" to mean employers that employ at least two, but no more than 50 eligible employees

ab 702 / insurance advertising

Requires licensees to include their license numbers on business cards, premium quotes and print advertisements.

ab 1360 / health

Authorizes a health care service plan or insurance carrier to enter contractual agreements with qualified associations.

Ab 1483 - sb 1052 / long term care

Major revisions in response to HIPPA requiring new disclosures of "tax qualified" and "non-tax qualified" long term care policies, including riders to life policies. A variety of new sales requirements and continuing ed changes are also included.

Ab 1650 / worker's comp

Establishes fraud and criminal prosecution charges for an employee who states he cannot perform work because of an injury from a previous employer yet he is found performing these tasks with a new employer.

Ab 1663 / health

Requires employers to establish a review process after 7/1/98 to examine coverage decisions regarding experimental treatments for insureds who meet certain criteria.

Ab 3013 / health care

Prohibits a health care provider or its contracting entities form interfering with a doctor communicating with his patient regarding treatment options, alternatives and other coverage arrangements.

Ab 3137 / insurers

Provides a transfer of all distributable property from a liquidated insurer to the Department of Insurance. Proceeds of selling this property is deposited in the Insurance Fund.

Ab 3233 / license fees

Provides that a fee increase paid by insurance licensees may not exceed 10% without the prior approval of the Legislature.

Ab 3234 / life

Regulates life insurance policy illustrations applicable to all group and individual life sales after 7/1/97.

Sb 1559 / health

Authorizes the formation of purchasing alliances for purposes of providing health benefits to employers and their employees.

Sb 1740 / health

Prohibits certain employers from disclosing genetic test results of an applicant or insured.

Regulation xxx / life
Changes the way reserves are calculated on life insurance plans effective 1/1/97 in California.

California Life & health Insurance Guarantee Association Act
Effective 2/96. Requires insurers and agents to give a policyholder clear notice that a policy is NOT covered by the CLHIGA. Exclusions include nonadmitted insurers, HMO's, Blue Cross, Blue Shield, unallocated annuity contracts, employer / association plans, synthetic guaranteed interest contracts, non guaranteed portions of policies (e.g. variable annuities), interest rate yields that exceed an average rate and any portion of a contract that provides dividends.

Fair claims settlement practices
New rules, effective 1/97, governing claim settlement practices for casualty, life, disabilty and health agents. Licensees must demonstrate compliance training.

SB 1052, SB 527, AB 1483 - LONG TERM CARE
Recent legislation has changed the selling of Long Term Care (LTC) as well as Continuing Education requirements. The passage of the above bills in 10/97 added or amended twnety three new insurance codes covering LTC issues such as policy construction, agent disclosures, required handouts, suitability standards and more. The changes also address **tax-qualified vs non tax-qualified policies** and introduce major marketing guidelines agents must follow to stay legal. New Continuing Ed requirements specify that all agents authorized to sell long term care take a new 8-hour course with a ***CTQ*** designation approval code prior to any client discussions on long term care products.