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CHAPTER ONE

FILING HEALTH INSURANCE CLAIMS

SORTING OUT HEALTH INSURANCE COVERAGE

Most people are confused about their health insurance coverage in that they are never really certain as to what they are entitled to collect. For the most part insurance policies are difficult to read and understand. We have had many people tell us that they are not certain that they are collecting all that they are entitled to.

It is estimated that over 40% of the people that incur costs for health care do not receive what they are entitled to or don't attempt to file a claim. Perhaps this chapter can eliminate confusion regarding health claims.

FIRST –

IT IS IMPORTANT TO DETERMINE THE TYPE OF POLICY AN INDIVIDUAL HAS AND IF THE BENEFITS ARE COORDINATED.

Millions of people have more than one insurance policy; therefore, it is necessary to file their claims in the proper order. In order to avoid lengthy claims processing and delays, or worse yet, have legitimate claims denied, individuals must be certain that their claims are filed in the proper order. Here are some tips on this procedure:

PRIMARY HEALTH INSURANCE POLICES

The primary policy is the one that is responsible for paying first. Should there be more than one policy, it must be determined which one is the primary policy.

SECONDARY OR SUPPLEMENTAL POLICIES

In the event that the primary policy does not pay 100%, a secondary or supplemental policy is designed to reimburse an individual for a portion, and in some cases, all of the difference. This is called "coordinating benefits" with the primary policy.

Individuals should provide the supplemental or secondary insurance company with evidence of what the primary policy has paid. That evidence is the EXPLANATION OF BENEFITS, (EOB) that is received from the primary insurance company.

Always make sure that your clients understand the order in which their policies coordinate benefits. Claims should never be sent to a supplemental or secondary insurance plan until you the explanation of benefits has been received from the primary plan. If it is not done in this fashion , unnecessary paperwork will be created and possibly will not receive any additional payment.

STILL UNCERTAIN OF THE DIFFERENCE BETWEEN PRIMARY AND SECONDARY COVERAGE?

Individuals employed and having coverage under more than one insurance plan, may have difficulty understanding, which of their policies is primary, and how the insurance benefits must be coordinated.

Here are some guidelines:

- ❑ Employed and Medicare Eligible. When an individual or married couple is over age 65, enrolled in Medicare, working full-time and enrolled in an employer's group plan (where there are more than 20 in the work force).
- ❑ The employer's group plan will provide primary coverage.
- ❑ Medicare will provide secondary coverage. That means the Explanation of Benefits from the employer's plans must be submitted to Medicare before Medicare will process the claim.
- ❑ Two income households. When both husband and wife are employed, both have medical insurance supplied by each of their respective employers and both are dependents under each other's policy.
- ❑ The husband's plan is primary for him and secondary for her. The wife's plan is primary for her and secondary for him.
- ❑ If children are covered under both policies, a "birthday" rule applies. The policy of the parent with the earlier birthday (month and day of the calendar year) will be primary for the children.

CATASTROPHIC HEALTH POLICIES

Catastrophic health policies usually provide secondary or supplemental coverage and provide benefits after a high deductible is met. It is important to keep track of the cumulative medical expenses to determine when an individual may become eligible for catastrophic policy reimbursement.

FIXED-COST POLICIES

Indemnity plans usually pay a fixed amount per day or week for a given illness when an individual is hospitalized or disabled and do not have coordination of benefits clauses. Most indemnity policies permit individuals to file claims when they are incurred for covered expenses.

CONFIRMING COVERAGE AND BENEFITS BY PHONE

There is no reason at all for individuals to get confused over trying to understand all their health insurance coverage. What's important is that individuals know whether they are covered for a particular illness or medical condition.

If the information can't quickly be found or understood in the policy handbook, There is a fast way to confirm what is needed to be known for accurate claims processing.

Individuals can call the insurance company's claims department to confirm their coverage and learn how to file their medical insurance claims for the current or anticipated medical bills. If an individual is covered by more than one plan, the individual should call each insurance company.

TO SAVE TIME:

- ❑ If the insurance company's telephone number is continually busy during the day, try calling at a non-peak time such as early morning.
- ❑ If Medicare is involved, there is no reason to call to confirm the coverage and filing requirements in advance. Hospitals, clinics, physicians, and other health care providers are required by Medicare to file the claim directly.
- ❑ Advise your clients to be prepared to discuss their current or anticipated medical condition and their insurance deductible, policy provisions, coverage areas and file requirements with the claims representative.

MAKING SURE TO EXPLAIN THE DEDUCTIBLES

Always confirm that the client knows how the deductible is calculated. Make sure they take notes concerning the specified amount of certain costs that they may incur before they can expect to receive any reimbursements. These costs can include the physician, hospital or any other providers such as ambulance service, etc.

Remember that deductibles are based what is considered by the company to be "reasonable and customary". Eligible expenses can be different from actual expenses. For example, if an individual incurs a \$300 expense, the insurance company may only consider \$150 of that bill to be reasonable and customary. As a result \$150, not \$300 is applied to the deductible.

If an individual has more than one policy, each may have a different way of figuring its deductible.

RENEWAL PERIODS FOR THE DEDUCTIBLE

Most policies require that a deductible amount be met each calendar year before claims will be paid. Since there are variations as to the length of time a benefit period runs once a deductible has been met always confirm the deductible renewal periods with your insurance company claims representative.

PREPARING A MASTER CLAIM FORM WILL SAVE TIME

You can assist your clients to save considerable time when filing future claims by preparing a Master Claims form.

To prepare a Master Claims form, take a blank insurance company claims form and fill in the following information in the appropriate boxes:

- ❑ The policy number, name, address and Social Security number of the insured.
- ❑ Any additional health insurance coverage that the family of the insured carries.

Then, whenever you need to file a claim simply make a copy of the Master Claim's form and fill in the information on your copy that pertains to the bills that you are submitting.

FOCUS POINTS

THE ART OF FILING HEALTH INSURANCE CLAIMS

1. The primary policy is the one that is responsible for paying first.
2. Secondary policies pick up all or some of the difference not covered by the primary policy.
3. Coordinating benefits is the process of matching a primary policy with an appropriate secondary policy.
4. Explanation of Benefits (EOB) provides the secondary insurance company evidence of what the primary policy has paid.
5. When both husband and wife are covered by family employer's policies, the husband's policy becomes the secondary for the wife and the wife's policy becomes secondary to the husband's policy.
6. If children are covered under both policies a "birthday" rule applies.
7. The "birthday" rule states that the policy covering the parent with the earlier birthday will be the primary policy for the children.
8. Catastrophic Health Policies usually provide secondary or supplemental coverage and provide benefits after a high deductible is met.
9. Indemnity plans usually pay a fixed amount per day or week for a given illness when individual is hospitalized or disabled and do not have coordination of benefits clauses.
10. Hospitals, clinics, physicians and other health care providers are required by Medicare to file claims directly.
11. Deductibles are based what is considered by the company to be reasonable and customary".
12. Most policies require that deductibles be met each calendar year.

CHAPTER TWO

HOW TO ELIMINATE PAPERWORK HEADACHES

The mounds of insurance paperwork can quickly baffle anyone with more than one bill from a doctor, hospital clinic or laboratory. This chapter will review the steps that will help your clients avoid this confusion.

ORGANIZE AND KEEP TRACK OF MEDICAL EXPENSES

The individual is the one responsible for ALL of their medical bills! Whether the hospital, the physician or other medical provider files a patient's health insurance claims, the patient will need to keep track of all expenses. Insureds should keep a different set of records for each family member since insurance companies pay claims on each individual insured.

Most people who are filing claims will already have accumulated more than one bill from a physician, hospital pharmacy, laboratory, clinic, ambulance, or other health care providers. Individuals should start by sorting all their bills and other paperwork such as receipts in date order by when medical services were received. Then make a record of these bills in date order. It will then be easy to identify insurance reimbursements and provider payments for specific bills when they arrive, and they will then be sure that they are collecting all the reimbursements to which they are entitled.

Always have your clients record all of their bills, even if the doctor, hospital or other providers are filing them directly with the insurance company.

- ❑ First, have them record the date or dates of service for each charge. This may be a single date or multiple dates if the provider's bill is for more than one charge.
- ❑ Have them fill in the name of the physician, hospital laboratory, pharmacy, medical supply company, ambulance, dentist, or physical therapist.

- Have them list all of the individual charges itemized on the provider's bill. This itemization will help them identify the EXPLANATION OF BENEFITS the insurance company sends them after it has processed their claim.

PREPARING AND KEEPING TRACK OF INSURANCE CLAIMS

For each of the bills, write the name of the insurance plan. If there are more than one insurance plan, list the primary carrier first. This will be the first insurance company to receive a claim from them or their medical provider. Then list any additional plans that they may have. If they have more than two insurance policies, list them in the order in which they coordinate benefits. This is the order in which they will be submitting their claims.

They should make sure that the policy covers the bills they are about to submit. If a bill is not covered by the policy, write, "not covered" and pay the bill.

Be sure to have them check the bills and other paperwork before attaching them to the now completed claims form. Be sure to have them attach to their claims form and original or photocopy of each provider's bill. Check to see that the bill has been correctly itemized and look for the provider's name, address and phone number. Also check to see that charges have been itemized and that there is a written diagnosis or diagnosis code listed on the bill. If a bill lacks any of this information, contact the physician or other medical provider for a properly itemized bill for insurance purposes. This will prevent unnecessary delays or claim denials.

Also, attach any doctor's **NOTE OF MEDICAL NECESSITY** for medical equipment; physical speech and occupational therapy, private-duty nursing care and private hospital room. The note must be written by the ordering physician and must include diagnosis and, when applicable, frequency and duration of treatment. Don't forget to put the policy number on each and every piece of paper you submit. Given the amount of paperwork insurance companies receive, this will prevent loss if the paperwork gets separated at the insurance company. Also, make sure they don't forget to list the bills submitted directly by the hospital, clinic, physician or other medical providers in their records. If the provider filed the claim, the insured will probably not know the date the claim was filed, so enter they should enter the date they are recording the provider's bill in their records as the date the claim was submitted. Then circle the date to remind themselves that the provider filed the claim.

ALWAYS! ALWAYS! ALWAYS! ALWAYS!

- . . . Be sure they make a photocopy of each bill claims form and any supporting material for their files before sending anything to the insurance company. To make there file copies quick and easy to locate in the

"open claims" file, prepare a follow-up sticker such as a Post-it note and have them jot down these reminders.

- ❑ The date they are submitting the claim or recording the bills their provider has submitted for them.
- ❑ The name of the insurance company receiving the claim.
- ❑ Clip the bills and any supporting material together and affix the follow up sticker to the top copy. Place the bills in the "Open claims" file in chronological order by the dates on the follow up sticker. Once again, have them get in the habit of recording their bills and claims and keeping this record in a safe place with all of their insurance records and policies, etc. When they do, they will always save time and frustration whenever they need to locate their bills and other materials to file with their secondary or supplemental plans, resubmit a lost claim, check the accuracy or reimbursements or remedy denied or underpaid claims.

UNTANGLING WHAT THEY OWE AND THEIR REIMBURSEMENTS

If your clients are like most people, when insurance company Explanation of Benefits begins to arrive, they will be confused and even overwhelmed.

That is because it is difficult to keep track of problems such as these:

- ❑ Which insurance claims have been paid. (This is especially difficult when an Explanation of Benefits statement does not include the name of the provider or when cumulative reimbursements for multiple charges of multiple service dates are combined).
- ❑ Whether those who have provided them with medical services have been directly paid by their insurance company.
- ❑ How to recognize an underpaid or denied claim. (This is particularly confusing when special messages are computer coded, making it difficult to know why a claim has been denied or underpaid.)

To overcome the preceding problems quickly and easily, have them match the dates and the amounts on each Explanation of Benefits statement they receive with the service dates and charges they entered in their record. They will want to note in their records whenever they receive an insurance company reimbursement check and for Explanation of Benefits.

- ❑ In one column, record the amount that the insurance company paid corresponding to the specific bill they recorded earlier in the first column.

- ❑ In the next column, have them record the date the reimbursement check was issued. This date can be taken from the check or from the date on the Explanation of Benefits.
- ❑ In the next two columns, check who received payment from the insurance company.
- ❑ Indicate "me" if they receive payment.
- ❑ Indicate "provider" if the provider received a check directly from the insurance company.
- ❑ Instruct them never to endorse an insurance check to a hospital physician or other provider. Always issue their own personal check or bank charge so they have a record of payment if there is an error in crediting their account.

FILING WITH THE SECONDARY OR SUPPLEMENTAL INSURANCE POLICIES

If they have more than one insurance plan, here is what they should do to avoid mistakes and collect all they are entitled to collect.

Have them begin by referring to their coverage notes and filing instructions on the work sheets and records they have kept on file. These notes are the ones they made when they originally phoned the insurance company representative. If their notes show; that, their additional insurance policy (or policies) coordinates benefits with the primary plan they will have to wait to submit bills for additional reimbursements until they have received their primary carrier's Explanation of Benefits.

This is the computer printout they receive from their primary carrier. It is the official proof the supplemental insurance carrier needs to process their claim for the unpaid balance. If they have an indemnity or other plan that does not coordinate benefits with their primary plan, have them submit and keep track of those claims as they would any claim with a primary plan.

When they file a claim with their additional insurance plan to correct unpaid balances, (i.e., with plans that coordinate benefits with their primary plan have them make sure to do the following:

- Photocopy the Master Claims form they have kept in their claims file. Then answer any remaining questions about the bills they are submitting.
- Attach both a photocopy of the itemized bill and the primary carrier's Explanation of Benefits for that particular bill.

- Attach a photocopy of any physician's note of medical necessity for those services ordered by that physician.
- They can easily locate the paperwork they will need to photocopy for any particular claim by referring to the original date the claim was filed that they noted in their records. Have them look for that date on the follow up sticker on the paperwork stored in their file folder marked "open claims".
- Be sure they put their policy number on every piece of paper they submit.
- Again, have them record the date that they are filing their claim to their back up insurance carrier and put a follow up sticker on their file copies with this date on it.
- Clip the copies together and store them in their open claims file in chronological order.

A FINAL REVIEW OF THE FILE

After they have received their Explanation of Benefits statement for each bill submitted by their insurance company or companies and recorded then, they will want to review their claims notes to make sure they have collected all the reimbursements to which they are entitled.

- Check for unpaid balances. If they see unpaid balances in their notes and have additional insurance coverage that coordinates benefits, file those claims immediately.
- Check for denied or underpaid claims. We will discuss in a later section on how to recover these claims.
- Check that proper payments have been made to their providers. If their insurance company has paid their provider, check to see if they owe any balance to their provider. If they have not paid their provider and have received an insurance reimbursement check, pay their provider the amount they initially recorded in their notes, then note this payment in the same records.

When their primary insurance and any secondary have accurately paid a claim or supplemental plans, clip the final Explanations of Benefits to the file they have marked "open claim". Transfer the completed claim to the "closed claims" file.

FOCUS POINTS

HOW TO ELIMINATE PAPERWORK HEADACHES

Fill In The Blank

1. The individual insured is the one responsible for ALL of their medical bills!
2. The insured (patient) should keep track of all expenses.
3. Insureds should keep a different set of records for each family member.
4. Maintain and sort all the bills and other paperwork such as receipts in date order by when medical services were received.
5. Note who received the payment or if the provider received a check directly from the insurance company.
6. Check to make sure that the policy covers the bills that are submitted.
7. Be sure to attach originals or photocopies of bills to the claim form.
8. Make sure the bill has been correctly itemized and has the name, address and phone number of the provider.
9. Watch for underpaid or denied claims.
10. Never endorse a check to a hospital or provider. Deposit the check and issue their own check as proof of payment.
11. Explanation of Benefits is a print out issued by the primary carrier and used by the supplemental insurance company to determine additional benefits.
12. Make sure the insureds put their policy number on every piece of paper submitted to the insurer.

CHAPTER THREE

UNDERSTANDING MEDICARE CLAIMS

DETERMINE IF MEDICARE IS THE PRIMARY COVERAGE

Most people who are eligible for Medicare will find that Medicare is their primary health insurance plan. Just the same, to avoid lengthy claims processing and reimbursement delays, you will want to review the guidelines that follow:

MEDICARE IS THE PRIMARY PLAN IF:

- ❑ The individual is retired or not working full-time.
- ❑ The individual is working full time, is enrolled in an employer group insurance plan and the company has less than 20 employees in the work force, or
- ❑ The individual is enrolled in the spouses employer group plan, and there are less than 20 employees in the spouse's work force.

MEDICARE WILL BE THE SECONDARY PLAN IF:

- ❑ The individual is working full time, is enrolled in the employer's group health plan and there are 20 or more people in the employer's work force. or,
- ❑ The spouse is working full time, and the individual is covered as a dependent in the spouse's employer group plan and there are 20 or more people in the work force of the spouse's employer.

HOW MEDICARE CLAIMS ARE FILED

IF MEDICARE IS THE PRIMARY PLAN:

IF AN INDIVIDUAL IS AN INPATIENT:

- ❑ The hospital will file the Medicare claim for the individual and it will receive payment directly from Medicare. All the insured needs to do is provide his/her Medicare number at the time they are admitted to the hospital.
- ❑ The hospital will bill the insured for "Medicare Part A Deductible" plus any additional costs for a private room (if not medically necessary) and incidentals not covered by Medicare (telephone calls, guest trays, etc.)
- ❑ On stays beyond 60 days, the insured will be billed for co-payments at Medicare specified amounts. Following hospitalizations, skilled nursing facilities will file for the insured only if they meet the criteria set by Medicare for approval

IF AN INDIVIDUAL IS AN OUTPATIENT:

- ❑ The hospital or clinic also will file the Medicare claim for the insured. Again, all they need to do is give their Medicare number to the hospital or clinic.
- ❑ Medicare will pay for 80 percent of the charges if the deductible has been met.
- ❑ The insured will be responsible for 20 percent of the Medicare processed charges.
- ❑ Medicare will pay certain laboratory tests with no patient share due.

PHYSICIAN AND OTHER PROVIDER RESPONSIBILITIES

Physician, independent therapists, medical equipment suppliers, ambulance services and so forth must file the insured's claim directly with Medicare. Again, all they need to do is give them their Medicare number.

- ❑ When the providers files the claim, they must tell Medicare how they want to be paid.

- ❑ When the providers accept Medicare assignment, they will receive payment directly from Medicare.
- ❑ The provider's fees will become whatever fees Medicare approves.
- ❑ Medicare will send the provider 80 percent of the Medicare approved amount after the deductible has been met.

(However, psychiatric services are paid at less than 80 percent)

When the physician or other provider does not accept Medicare assignment...

- ❑ The insured will be billed for the total cost of the health care services received.
- ❑ The insured will be responsible for paying your health care provider's entire bill.
- ❑ The insured will receive a check from Medicare with an Explanation of Medicare Benefits stating Medicare approved amounts for each charge the provider filed.

WHAT IF MEDICARE IS THE BACK UP PLAN?

This is how the claims are filed.

IF THE INSURED IS AN INPATIENT

- ❑ The hospital will file the necessary claims with Medicare for any unpaid balances not paid by the primary insurance carrier.
- ❑ All the insured has to do is provide both the primary insurance information and their Medicare number at the time of admission. Have them be sure to tell the hospital that Medicare is their secondary coverage.

IF THE INSURED IS AN OUTPATIENT

- ❑ The hospital or clinic will file with Medicare for any unpaid balances not paid by the primary insurance.

- ❑ All the insured individual needs to do is provide their Medicare number to the hospital or clinic and advise them that Medicare is their secondary coverage.
- ❑ If the primary carrier pays the hospital or clinic directly, the hospital or clinic will file the claim with Medicare for any unpaid balance.
- ❑ If the primary carrier reimburses the insured for their outpatient hospital or clinic charges:
 - ❑ The insured will need to provide the hospital or clinic with the Explanation of Benefits the primary carrier has sent them. They will then file the Medicare claim for the unpaid balance.
- ❑ Be sure the insured pays their hospital or clinic what the primary plan has paid them by their own personal check or bank charge.

Physician or other provider responsibilities:

- ❑ Be sure to ask the physicians or other providers whether they accept Medicare assignment.
- ❑ If the provider accepts Medicare assignment send the provider the primary carrier's Explanation of Benefits. The provider must then submit a claim directly to Medicare.
- ❑ If the provider does not accept Medicare assignment the insured should submit itemized bills with their primary carrier's Explanation of Benefits to Medicare for payment on the unpaid balance. The insured will receive payment directly from Medicare.

UNDERSTANDING THE MEDICARE EXPLANATION OF BENEFITS

Keeping track of Medicare paperwork can be a major job. Often the insured may have to keep track of 10, 20, 50 or more separate charges for fees, tests and supplies that have been submitted by the respective providers to Medicare. Then the insured must make sure that all their providers are paid and that they have collected all they are entitled to collect. For each and every charge they have for medical services, they need to match...

- ❑ Who provided them with specific medical service on various dates, the charges, what method of payment they used and what balances they still owe them?
- ❑ Whether Medicare has processed all the charges submitted by their providers with what Medicare has paid, the accuracy of payments and who received payments.
- ❑ What charges the Medicare supplement or the secondary carrier has paid or is still processing, the accuracy of payments and who received payments.

Fortunately, the records the insured has been keeping will help them keep track of their bills, reimbursements, and payments and will prevent what would otherwise be an overwhelming paperwork nightmare. Again, as we have discussed earlier, they should follow the same procedures for keeping track:

Sort all their bills in date order then make a record of the following:

- ❑ The dates of service for each individual bill.
- ❑ The names of the doctors or other providers.
- ❑ The amounts of each bill (make sure they list each item if the bill is itemized) this will help them interpret their Explanation of Benefits when it arrives.
- ❑ Write Medicare or any names of Medicare supplement or other insurance policies they may have.
- ❑ The date that they are submitting the claims.
- ❑ Again, sort all bills by date order, prepare the Master claims form by filling in all information they can that is not related to their bills. Make copies of their Master claims form then fill out the copies with the information directly related to each bill. Attach all bills and any additional information they may have that is related to that bill **AFTER THEY HAVE MADE COPIES OF EACH AND EVERY PIECE OF PAPER.** (Also, again, make sure they have written your policy number and / or Medicare number on each bill). This is to protect against their paperwork getting separated at the insurance company.

To make that their medical bills, claims, and other paperwork is easy to find when they need them, have them prepare a sticker with the date they have listed the bills in their record that the provider filed with Medicare and write "Medicare" and affix the sticker to those bills. Then clip the bills together and place them in chronological order by the dates on their follow up stickers. When they do this, they will quickly be able to find their paperwork in the file folder they have prepared for "open claims". Whenever they need

to file with their Medicare supplement and / or other insurance policies after their Explanation of Medicare Benefits arrives, have them verify the accuracy of reimbursements, identify and remedy denied or underpaid claims, and arrange to have lost claims resubmitted.

When they begin to receive their Explanation of Medicare Benefits, they will want to identify promptly which charges have been processed and confirm and that their Medicare claim was properly paid. They will then want to file claims with their Medicare Supplement or other secondary insurance policy immediately.

As they receive their Explanation of Medicare Benefits, they will want to make notes in their records identifying that physician hospital clinic and / or other provider's charges were processed on the EOMB.

- ❑ Match the providers' name, dates of service and charges described in the EOMB.
- ❑ After they have matched the EOMB with their charges, record the amount that Medicare paid for the charge in the last column of their records. This will be 80 percent of the Medicare approved amount once the Medicare deductible has been met. Don't let them become confused over what Medicare calls the approved amount.

REMEMBER

- ❑ For all medical services, Medicare has established an approved fee.
- ❑ Often that amount will be less than what the provider has billed them for services.
- ❑ Examine the difference between the Medicare approved amount and provider's charge. If there is a significant difference between the Medicare approved amount and what their provider charged on a Medicare non-assigned claim (i.e. when the provider wants to be paid by them and not Medicare) they may want to request that Medicare review the claim for a possible error.
- ❑ Have them record the date of the Explanation of Medicare Benefits computer printout. Then check who received the payment from Medicare in their records? Again check "me" or "provider".

CAUTION

Again, be sure that they never endorse a Medicare check to a doctor or other provider. Always issue their personal check or bank charge so they have a record of payment. |

When a provider accepts Medicare assignment, they may not receive the provider's bill until after they receive their Explanation of Medicare Benefits. That is because many providers want to know what amount Medicare has approved before billing the patient for the balance of the Medicare approved charge.

COLLECTING THE PROPER REIMBURSEMENT FROM THE MEDICARE SUPPLEMENT

If they have a Medicare supplement or secondary insurance, they should not ever submit a claim until after they have received their Explanation of Medicare Benefits that details what Medicare has paid on their claim. That is because the Explanation of Medicare benefits is the official proof that the other insurance carrier needs to process the claim on the unpaid balance.

In some instances, providers will bill supplemental or secondary carriers after Medicare pays them. And a few supplemental carriers have made agreements with Medicare to have claims processed automatically at the time Medicare claims are settled.

Despite these exceptions, the patient is ultimately responsible for any unpaid balance. Therefore, it is wise to have the insured maintain up to date records up and all their paperwork organized in dated order in their file marked "open claims". This will help them avoid paperwork nightmares when provider's final bills are received.

To assure themselves that they will get full reimbursement on all their claims, they should always call the Medicare supplement's claims department to confirm what they are entitled to collect. Then record what they learn in their notes.

When the claims representative answer, they should be prepared to give their name and policy number. Then ask the following questions and be prepared to make notes on the answers in their record.

- ❑ Does Medicare supplement policy have a deductible?

If it does, ask:

- ❑ The dollar amount of the deductible.

- ❑ How the deductible is calculated?
- ❑ How often the deductible must be renewed?
- ❑ What does the Medicare supplement policy pay?
- ❑ The balance to the Medicare approved amount.
- ❑ The balance to the full amount charged by the provider and/or
- ❑ Reimbursement for prescription drugs, private duty nursing, private room and other costs not paid by Medicare.

WHAT ARE THE FILING REQUIREMENTS?

Some Medicare supplements require only a copy of the Explanation of Medicare Benefits with their policy identification number at the top of the page. Others require that the insured submit a claims form with their Explanation of Medicare Benefits and copies of all their itemized bills, notes of medical necessity and so forth.

FOCUS POINTS

UNDERSTANDING MEDICARE CLAIMS

1. Most people who are eligible for Medicare will find that Medicare is the primary health insurance plane.
2. Medicare is the primary plan if an individual is retired or not working full time.
3. Medicare can also be the primary plan if an individual is working and enrolled in an employer group plan of less than 20 employees.
4. Medicare can be the primary carrier if the insured is enrolled in a spouse's employer group plan of less than 20 employees.
5. If Medicare is the primary provider and the insured is an inpatient, the hospital will file the claim with Medicare.
6. If Medicare is the primary plan and the insured is an outpatient, Medicare will pay 80 percent of the charges if the deductible was met.

7. Medicare will pay certain laboratory tests with no patient share due.
8. When a medical provider accepts Medicare assignment, they will be paid directly by Medicare and must accept whatever fees Medicare approves.
9. If no assignment is made by the insured, the insured will be responsible for any unpaid portion not paid for by Medicare.
10. Primary providers furnish insureds an Explanation of Medicare Benefits form stating Medicare approved amounts for each charge the provider filed.
11. If Medicare is the secondary plan the hospital will file the necessary claims with Medicare for any unpaid balances not paid by the primary carrier.
12. The Explanation of Medicare benefits form is the official proof the secondary carrier needs to process the claim for the unpaid balance.
13. The patient is ultimately responsible for any unpaid balances.
14. Medicare supplement policies pay the balance to the Medicare approved amount, the balance to the full amount charged by the provider and or reimbursed for prescription drugs, private duty nursing, private room and other costs not paid by Medicare.

Essay

1. When will Medicare be your primary plan?

2. When will Medicare be your secondary plan?

CHAPTER FOUR

COLLECTING DENIED & UNDERPAID CLAIMS

REASONS CLAIMS ARE DENIED OR UNDERPAID

Basically, there are four reasons that a Medicare claim can be denied or underpaid.

- ❑ Errors caused by omission of information.
- ❑ Insurance coverage disputes.
- ❑ Errors made by clerical personnel
- ❑ Failure to follow the carrier's regulations.

ERRORS CAUSED BY OMISSION OF INFORMATION

Here are some pitfalls to be aware of. Make certain the claims contain the following information.

- ❑ Be certain the proper diagnostic code appears on the claim.
- ❑ Be certain the claim shows an itemized bill not just the balance due.
- ❑ Be certain the bill contains the provider's number.
- ❑ Be certain that the diagnostic code is correct, (it's possible to obtain a list of these codes from the doctor).
- ❑ Should the claim contain any special equipment or other out of the ordinary expenses, a physician's "Note of medical necessity", must be submitted.

INSURANCE COVERAGE DISPUTES

The following are areas in which insurance coverage disputes can occur.

- ❑ The service is not covered by the plan they have purchased from the insurance carrier.
- ❑ The amount they were charged is more than what is considered "usual reasonable and customary" for the geographic area.
- ❑ The insured received a service considered by the carrier to be routine, but in fact, was not routine.

ERRORS MADE BY CLERICAL PERSONNEL

Human's process claims, and humans make errors. When you consider that hundreds of thousands of claims are processed each month, you have to expect that information can be either:

- ❑ Keypunched incorrectly.
- ❑ Numbers inadvertently reversed.
- ❑ Misplaced paperwork.
- ❑ Paperwork that cannot be identified as belonging to the insured.

FAILURE TO FOLLOW THE CARRIER'S REGULATIONS

Often, the fact that insureds do not carefully read the carrier's regulations concerning claims can pose major problems.

A couple of examples are as follows:

- Some hospital admissions require that the insured obtain a pre-certification from their carrier. (Except in emergencies, of course). A telephone call to the carrier can help solve this problem.
- Should the insured require an operation, some carriers require a second opinion. Failure to do so could cause a denial of claim.

IF UNCERTAINTY ENTERS THE PICTURE

Should the insured be confused or uncertain as to why a claim was denied or not paid, often, a call to the claims department can settle the issue. Before calling, have the following information available.

- Policy number.
- Date of disputed service.
- Amount of underpaid claim.
- Amount actually paid.
- Amount you feel is incorrect.
- Reason you feel claim is incorrect.

WHEN THE INSURED KNOWS THE REASON FOR DENIAL OR UNDERPAYMENT

They have the following remedies available to them in this situation:

- ❑ Dispute over coverage. Call the carrier and ask for a letter that explains why the claim in question were either not routine, or not usual reasonable, and customary.
- ❑ Clerical errors, again call the carrier and provide them with the information that proves that a clerical error has been made and often, the correction can be made right on the phone.
- ❑ Omission errors, if made by the physician or other provider, can be corrected by simply requesting that a corrected statement be sent. Again, be certain that all pertinent information previously discussed, diagnostic code, provider's name, etc. is contained on the corrected bill.

SENDING LETTERS TO THE INSURANCE CARRIER

Although this may sound elementary, the contents of a letter will be directly related to the response and satisfaction desired.

Therefore the letter should contain the following:

- ❑ Be certain to have the correct address of the insurance company.
- ❑ Be certain the name and address for return correspondence is in the letter.
- ❑ Policy number.
- ❑ Claim number.
- ❑ Directed to the attention of a specific department if possible.
- ❑ Better yet directed to an individual's name if possible.

The body of the letter should contain the following information concerning your inquiry.

- Who
- What
- Where
- How
- Why
- When

Finally, be certain the letter is signed and includes the insured's current phone number and after a reasonable length of time has passed, (10 days or so) a follow up inquiry may be necessary.

FINAL MEASURES

If after all else has failed, or if they have received a negative resolve to their dispute, they have one final step.

- ❑ Contact the State Department of Insurance and specify the office that licenses the insurance carrier. There will be a representative in that department that will assist in filing a written complaint.

FOCUS POINTS

COLLECTING DENIED AND UNDERPAID CLAIMS

1. There are four reasons that a Medicare claim can be denied or underpaid. Omission of information, insurance coverage dispute, clerical error, and failure to follow the carrier's regulations.
2. Be aware of errors caused by omission of information such as wrong diagnostic code, lack of itemized bill, or missing provider number,
3. Insurance coverage disputes usually occur in the area of wrong plan purchased, charges not "usual and customary" or services not considered routine.
4. Clerical errors normally causing disputes include keypunch errors, reversed numbers, misplaced paperwork, or paperwork that cannot be identified as the insured's.
5. Some claim disputes arise as a result of failing to follow the insurer's regulations and procedures.
6. When sending a letter to an insurer be sure to include your return address, policy number, claim number and is directed to the proper individual or department.
7. If the insured receives a negative resolve to their dispute, the final step is to contact their State Department of Insurance.

Essay

1. What are the main areas in which insurance coverage disputes can occur?

2. What are three main remedies available for collecting denied or underpaid insurance claims?

3. When sending a letter to insurance carrier, what should the letter contain?

CHAPTER FIVE

RECONCILING WITH PROVIDERS

UNPAID MEDICAL BILLS

Providers such as physicians, clinics or hospitals expect to receive payment for services rendered within a reasonable amount of time.

Claims typically take four to six weeks to process assuming that they are **SUBMITTED CORRECTLY**. Many providers have taken on the task of assisting in claims filing to enable them to receive their payment in a more timely fashion.

For example, some providers use two systems:

- ❑ Super bills that are pre-designed to provide the carrier with all needed information.
- ❑ Filing claims on behalf of the insured directly with the insurance carrier and eliminating the middleman.

SERIOUS ILLNESSES

Often, a serious illness runs up an expensive hospital bill. Most health providers are sensitive to these expenses and the financial devastation they can wreak on the insured and their family. For the most part these folks will grant some patience in waiting for payment. Should a provider be insensitive to the insured's needs, perhaps contacting an attorney might be their best alternative.

INSUREDS SHOULD BE UPFRONT WITH FINANCIAL HARDSHIP

Most people who have money due them have stated that they are more than willing to work with the debtor. The number one complaint from people who have money due them is that the debtor refuses to answer calls, letters or attempts to work out a fair payment agreement. Insureds might want to give their health provider evidence that all the money they have received from their insurance carrier has been properly applied to those due the money.

Often, an understanding provider will accept what the insurance carrier has paid the insured as payment in full. Others have been willing to reduce their fees to help the situation.

HOSPITAL BILLING ERRORS

We know that studying a hospital bill can be very difficult and time consuming, however, reviewing hospital bills for errors is always a good idea.

Look for the following:

- ❑ Supplies never given.
- ❑ Services not received.
- ❑ Discrepancies in private vs. semi-private rooms.
- ❑ X-rays never taken.
- ❑ Medication not prescribed.

EXCESSIVE CHARGES

Should a claim be denied because the carrier feels that the charge was excessive and did not fall within the "usual reasonable and customary" fee, contact the physician or health provider that is involved in the excessive charge. Often, the fee is fair and reasonable and since the carrier is not given all the facts, the claim is paid for a lesser amount.

Here is what to do should this happen:

- ❑ Was there a service given to above the norm? In other words, was the carrier explained the additional service in detail to justify the additional charge.

- ❑ Often, a letter from the physician can clarify the reason for an excessive charge.
- ❑ Be certain that the diagnostic and procedure code on the claim matches the actual service received.

For the most part insurance carriers want to pay fairly and promptly for reasonable and legitimate medical care. In closing, we would like you to understand that the major causes for differences of opinion in health insurance claims is as follows:

- ❑ Lack of information. You can never give too much information, but in fact, most claims do not have enough.
- ❑ Knowing what the policy pays and does not pay.
- ❑ Knowing the proper language to use is important

FOR EXAMPLE:

If a business owner wants to close for the Easter holidays, including Good Friday, so that he can have a three day weekend, he must be careful how he tells his customers that he will be closed. For example, putting a sign on the building that say's "Closed for Good Friday" maybe misunderstood. Think about it.

FOCUS POINTS

RECONCILING WITH PROVIDERS

1. Claims typically take four to six weeks to process assuming that they are SUBMITTED CORRECTLY.
2. Super bills that are pre-designed to provide the carrier with all needed information.
3. Some providers file claims on your behalf directly with the insurance carrier and eliminate the middleman.
4. Being up front with a provider about financial hardship often times leads to a reasonable payment plan.
5. Often, an explanation letter from the physician can clarify the reason for an excessive charge.

6. Be certain that the diagnostic and procedure code on the claim matches the actual service received.
7. Major causes for differences of opinion in health insurance claims are lack of information and knowing what a policy pays or does not pay.

Essay

1. What should an individual look for when reviewing their hospital bills for errors?

2. What are the major causes for differences of opinion in health insurance claims?

CHAPTER SIX

LONG TERM CARE POLICIES

THE NEED FOR LONG TERM CARE

We have had many opportunities to stand before large audiences and present our long-term care policy course. Probably the most disheartening survey we have ever conducted in front of an audience was to ascertain the following:

1. How many in the audience have had a loved one in a long-term care facility?
2. How many in the audience currently have a loved one in a long-term care facility?
3. How many in the audience contemplate having a loved one in a long-term care facility in the very near future?

To our amazement, an average of better than 70% of those in the audience raises their hands. Many of them were kind enough to take the time to share their sorrows with us concerning their loved ones and long term care. We have seen many teary-eyed audience members tell of the heartache and the financial devastation that long-term care brought to their families.

We hope this guide will give you a better understanding of long-term care and perhaps convince you or someone you know for the need for this very important coverage.

I recall one story in particular where an elderly lady named Alice had recently lost her husband of 45 years. She got along relatively well for 8 or 10 years following his death. Her grown children, Mark and Helen, soon began to notice changes in her behavior. Alice used to pride herself on the fact that she could always balance her checkbook to "the exact penny". This was increasingly becoming a simple accounting principal she could no longer conquer.

One day, while at the doctor's office, Alice became lost and was more than an hour and a half late getting home. Needless to say, her children were frantic. Upon arriving home, Alice had her story all prepared. Although she knew that she had become lost she convinced her children that she was window-shopping and time had just "got away from her". Soon her grandchildren began noticing drastic changes in her behavior. At family get-togethers, she would go off into a corner and withdraw and isolate herself. She had been having trouble with her arthritis and her eyes and everyone wrote it off to the medication she was taking.

One day, the reality of it all finally came to a head when her son, Mark, received a call from his mother. It was obvious she was upset and crying. She asked Mark if there was any money at home for her to take a cab? Mark inquired as to the whereabouts of her car. Alice went on to tell him that she had gone to the Division of Motor Vehicles to take her driving test in order to renew her license and that she had failed and the licensing officer would not permit her to drive her car home. Mark immediately left work and drove to the Division of Motor Vehicles to meet with the licensing officer. The, officer told Mark that not only did his mother incorrectly answer 80 percent of the questions, but more were not answered at all. He went on to say that during the driving test, his mother was disoriented and lost her way.

Mark and Helen had a family meeting that evening and decided that it would be best to have their mother take a physical exam to determine what was going on. Following the exam the next week, the doctor told them that their mother had the beginning stages of Alzheimer's disease and that this situation was going to get progressively worse.

A couple of month's later Alice suffered a stroke, was unable to speak and could no longer care for herself. In a tearful moment at the hospital emergency room, Mark and Helen finally admitted to each other that the real reason they were pretending nothing was wrong. It was because they had checked into the cost of a long-term care facility and were amazed to find that it ran from \$25,000 to \$52,000 per year. They also admitted that neither of them would be able to put this additional financial burden on their families.

While preparing their mother for the nursing home, Mark found a policy neatly tucked away under some linens in his mother's closet. To his amazement, he found that his father, prior to his death, had purchased a long-term care policy that included Alice. The policy paid up to \$100 per day for life and was still in full force and effect since their father had paid it in full at the time of purchase.

Surely this is a case of a long-term care policy being a lifesaver. Let's see how they work:

SOME STARTLING FACTS

We had the privilege of having a Registered Nurse in one of our audiences. She asked if she could share some disheartening facts with us and we invited her to do so. She told us that there were 120 folks in her long term care facility. Of those 120, she told us that 40% (or 48 people) were under the age of 65. Imagine 4 out of 10 in this nursing home were under the age of 65. Our first question to her was for what reason were these 48 people admitted to a long-term care facility? 3 were teenagers who were brain-dead due to a serious automobile accident. The other 45? To our amazement each and every one was there as a result of STROKES!

She went on to tell us that of the 120 patients, NOT ONE was paying for their care with a long-term care policy benefit. Who was paying for the care? 29 of the 120 were paying with personal checks from their lifetime savings. 89 were receiving Medicaid benefits and 2 were receiving Medicare benefits that only pays for skilled nursing care.

Another misnomer is the length of time a person stays in a long-term care facility. They say it's 456 days. However, when we survey our audiences and ask them to shout out how long their loved one has been in a long-term care facility, we get an average of over 9 years. Where does the 456 days come from? It comes from the fact that over 50% spend less than 90 days in a nursing home and this distorts the real numbers that affect most people and do the most financial damage.

One factor that is rarely considered is the emotional damage that is done to an elderly person that is removed from loved ones and familiar surroundings to be placed in a long term care facility. Statistics show that the mental and physical health of a person improves dramatically if they could only stay at home.

WHO NEEDS LONG TERM CARE

For the most part we feel that long term care is only for the elderly. Quite the contrary. In 2000, there were approximately 8 million Americans, 65 or older, who required long term care. And by the year 2036 that figure will be 19 million plus!

HISTORY OF LONG TERM CARE

Long term care is not a now concept or idea. They first appeared on the scene in the early 1980's, but were very primitive in nature and had numerous stipulations, requirements and exclusions that put them into the "Hit by a cow on the third of the month providing there was a full moon" category.

Insurance companies were reluctant to get into this market simply because there was not previous claims experience that they could follow. Actuarial science could not be applied and there were no records on who went into long term care facilities, when, for what and how long. Needless to say, this posed major obstacles in the pricing of the product.

LONG TERM CARE AND STANDARD PROVISIONS

If you will recall the Medicare fiasco where elderly people were found to own four or five different Medicare supplement policies, when only one was necessary, you can appreciate the fact that the National Association of Insurance Commissioners are in the process of designing "standard long term care policies". The insurance companies will be required to sell the same type of policies with the same coverage and the same restrictions. This will eliminate confusing policy language and misunderstandings of exactly what is, and is not covered.

In all likelihood, some of the major standard provisions will probably be as follows:

- ❑ No prior hospitalization confinement necessary.
- ❑ All levels of care will be fully covered.
- ❑ Standardization of waiting and benefit periods.

WHAT TO LOOK FOR IN LONG TERM CARE

The most important feature to consider is what type of benefits the policy provides. The four most common long-term care benefits are as follows:

1. Skilled nursing care.
2. Intermediate care.
3. Custodial care.
4. Home health care.

Let's review each of these so that you completely understand the differences.

SKILLED NURSING CARE

Skilled nursing care is the most expensive. It requires a prescription from a qualified licensed physician. The care must be continuous on a 24 hour a day basis and you are to be cared for by a Registered Nurse.

INTERMEDIATE CARE

Although a doctor's prescription is not necessary for this level of care, it does require medical care under the supervision of medical personnel it must be administered by a Registered Nurse, Licensed Practical Nurse, or a Physical Therapist.

CUSTODIAL CARE

Custodial care assists the patient in meeting "Activities of daily living", also referred to as "ADL's". ADL's are as follows:

- ❑ Mobility
- ❑ Dressing
- ❑ Personal Hygiene
- ❑ Eating

HOME HEALTH CARE

Under this care, the patient is not confined to a nursing home and is usually able to care for him or herself. Usually a non-medical type person assists in shopping, meal preparation and some physical therapy.

OPTIONAL BENEFITS

Two of the more common optional benefits are:

- ❑ Hospice

- ❑ Adult Day care
- ❑ Inflation Protection
- ❑ Waiver of premium

HOSPICE

This provides the terminally ill with comfort in their last days and does not prolong treatment or employ life saving devices. Typically a hospital bed is set up in the patient's home to keep them in familiar surroundings with family members their last days. Depending on the severity of pain or medical needs, home visits are made by Registered Nurses as well as Social Workers. This is a wonderful organization that provides care to the rich and poor and truly does make the last days as comfortable as possible.

ADULT DAY CARE

This care is usually given at a center that caters to those that are mentally or physically impaired. A typical day at the center provides social activity, medical care, meals and transportation to and from their home.

INFLATION PROTECTION

An important option is inflation protection it provides for future increases in the daily benefit. Most policies offer a 5 percent increase in the daily benefit each year. Long term care is not immune to inflation and it is a safe assumption that nursing home care is going to do nothing but go up.

WAIVER OF PREMIUM

While optional most companies include waiver of premium as a standard provision. Typically, once you have been confined and receiving benefits for more than 90 days, the policy premiums will be paid by the company.

HOW LONG WILL BENEFITS BE PAID

This depends entirely on the type of policy the insured purchased. The cost factor enters into this question also. Most companies offer benefits of from one to five years, some even for lifetime.

PRE-EXISTING CONDITIONS

Most policies make provisions for pre-existing conditions. Most pre-existing conditions are measured by excluding any condition for which you were treated or given medical advice for the period of six months prior to the effective date of coverage. Additionally, the pre-existing clause continues for six months following the effective date of the policy. So in reality, you are looking at a year.

EXCLUSIONS

You must be aware of the exclusions that long-term care policies contain. Claim time is not when you want to find out. In the early long term care policies, they would exclude Alzheimer's disease by saying that "the policy excludes diseases of an organic nature" which was their way of excluding Alzheimer's without mentioning the disease by name. This has since been rectified because Alzheimer's disease and other organic diseases are now covered in most policies that we have seen.

Here are some of the more common exclusions:

- ❑ Care given in a Veteran's hospital.
- ❑ Losses that Workers' Compensation provides for.
- ❑ Mental psychoneurotic, or personality disorders that are not the result of organic or physical disease.
- ❑ War.
- ❑ Self inflicted injuries that are intentional

LONG TERM CARE POLICY RIDERS

It is now possible to purchase a life insurance policy or a disability income policy and add long term care as a rider. The rider is very much like the standard long-term care policy in that it affords you the same elimination periods, benefits periods and levels of care.

LIVING BENEFIT LONG TERM CARE RIDER

This rider permits terminally ill patients to use life insurance proceeds in advance to cover expenses connected with their illness. Typically, this option will make available to the insured 70 to 80% of the death benefit they are entitled to cover the cost of nursing home care. Another option in this category is receiving 90 to 95% of the death benefit they are entitled to because they are terminally ill.

FOCUS POINTS

LONG TERM CARE POLICIES

1. Long term care concept was first introduced in the early 1980's
2. Insurance companies were first reluctant to get in this field because there was no previous claims experience
3. The lack of actuarial science in this field made it difficult to price.
4. The four most common long-term care benefits are skilled nursing care, intermediate care, custodial care, and home health care.
5. Skilled nursing care is the most expensive form of care.
6. Skilled Nursing care requires the aid of a Registered Nurse.
7. Intermediate Care requires the supervision of medical personnel and administered by a Registered Nurse, Licensed Practical Nurse, or a Physical Therapist.
8. Custodial Care assists the patient in mobility, dressing, personal hygiene and eating.
9. Home Health Care uses a non-medical type person to assist with shopping, meal preparation, and some physical therapy.

10. Hospice care provides terminally ill with comfort in their last days and does not prolong treatment or employ life savings devices.
11. Adult Day Care is usually given at a center that caters to those that are mentally or physically impaired.
12. How long benefits are paid depends on the policy.
13. Most policies make provisions for pre-existing conditions.
14. Long Term Care policies have exclusion clauses.
15. Long Term Care policies can be added as riders to some life insurance policies
16. Living Benefit Long Term Care Policies permit terminally ill patients to use life insurance proceeds in advance to cover expenses connected with their illness.

CHAPTER SEVEN

UNDERWRITING & LONG TERM CARE POLICIES

SOURCES OF INFORMATION

The underwriting process employs four important sources of information.

- ❑ The application.
- ❑ The agent.
- ❑ Verification reports.
- ❑ Medical records and history.

THE APPLICATION

Obviously, the application provides the company with the basis upon which they will make the decision to issue a contract. Questions need to be answered in full with honesty and integrity.

THE AGENT

Years ago, you were permitted to take applications by mail or phone so long as they were signed by the applicant. Today, however, companies want to know that the agent actually sees the applicant and assists in the field underwriting. You will be able to make observations unavailable to the home office underwriter.

VERIFICATION REPORTS

The verification reports provide investigative information to verify statements made by the applicant. These reports also sometimes produce additional information or problems that may not have been listed on the application.

MEDICAL RECORDS AND HISTORY

Often times, companies employ the Medical Information Bureau (MIB) as well as Attending Physician's Reports, (APR's) in verifying medical records and history. Obviously, this information is extremely important in the underwriting process.

SUBSTANDARD UNDERWRITING

Not all applications are approved as submitted or issued standard. Often, the applicant is required to pay more than the standard premium in order for the company to absorb certain hazard or risks.

Factors that directly affect whether the policy will be issued standard or substandard are:

- ❑ Pre-existing conditions
- ❑ Age
- ❑ Occupation (if applicable)
- ❑ Moral issues
- ❑ Current, past and possible future medical conditions

FOCUS POINTS

UNDERWRITING LONG TERM CARE POLICIES

1. Underwriting applies four sources the application, the agent, verification reports and medical records and history

2. The application provides the basis for the insurer to make the decision to issue the policy.
3. The agent assists the underwriting process by field observation.
4. The verification reports provide investigative information to verify statements made by the applicant.
5. The Medical Information Bureau is often used to verify medical records and history.
6. Policies are issued as either standard or substandard.
7. Factors effecting the level of policy include pre-existing conditions, age, occupation, moral issues, medical conditions.

Essay Quiz

1. What important sources does the underwriting process employ?

2. What does the application provide to the company?

3. What role does the agent play in the underwriting process?

4. What is the difference between whether a policy is issued as standard or substandard?

CHAPTER EIGHT

POLICY PROVISIONS

Years ago, the National Association of Insurance Commissioners developed a model Uniform Policy Provision Law. They established 23 policy provisions of two types. 12 that are required to appear in all policies and 11 that are option and may be used at the discretion of the insurance companies to better customize their policies. One rule that is strictly enforced is that no substitute language may be used in any provision unless the substitute language is in favor of the insured.

REQUIRED POLICY PROVISIONS

- ❑ Entire Contract
- ❑ Time limit on certain defenses.
- ❑ Reinstatement
- ❑ Claim forms.
- ❑ Grace period.
- ❑ Notice of claims.
- ❑ Time payment of claims.
- ❑ Proof of loss.
- ❑ Claimant payment.
- ❑ Autopsy or physical exam.
- ❑ Change of beneficiary.

- Legal Action.

ENTIRE CONTRACT

A policy including all attached papers constitutes the entire contract. Riders, endorsements and changes must be approved in writing and executed by an officer of the company. The agent does not have permission to change or waive any policy provision.

TIME LIMIT FOR CERTAIN DEFENSES

This provision is more commonly referred to as the "period of incontestability". It is usually two years in length. Should an application contain any fraudulent statements, the policy's period of contestability shall be extended to the life of the contract. The only exception is a "guaranteed renewable policy" in that once the period has expired, the policy cannot be contested even if fraudulent statements were made on the application.

REINSTATEMENT

A policy that has lapsed may be reinstated under certain conditions providing the proper procedure is followed. Some companies require an application for reinstatement, which may or may not be approved.

CLAIM FORMS

Companies are required to supply you with a claim form within 15 days after receiving a claim. Should they not meet this requirement, you may submit proof of loss on any form you choose.

GRACE PERIOD

Normally, 31 days this is the time the company gives you to make a delayed payment without penalty and with the policy remaining in force.

Should payment not be made by the end of the grace period, the policy will lapse and for terminate.

NOTICE OF CLAIMS

You are required to notify the company within 20 days or as soon thereafter as is reasonably possible.

TIME PAYMENT OF CLAIMS

This provision stipulates that "the company must pay the claim immediately". Usually payment of claim is made within 60 days.

PROOF OF LOSS

You are given 90 days in which to submit proof of loss. Should you be unable to meet this 90 days deadline, your claim will not be affected if it was reasonably possible for you to do so.

CLAIM PAYMENT

Payment for losses of life would be made to the designated beneficiary. Should a beneficiary not be made payment will go to the insurer's estate. Also the insured has a right to request a payment be made directly to the hospital or physician that rendered services.

AUTOPSY OR PHYSICAL EXAM

The company can request at its own expense, physical exams. So long as law does not forbid it, the company has a right to request an autopsy on the body of the insured.

CHANGE OF BENEFICIARY

The insured has a right to change the beneficiary at any time except if an irrevocable beneficiary has been designated.

LEGAL ACTIONS

Should you have a dispute with the company in regards to a claim you must wait at least 60 days and no longer than 5 years to take legal action.

OPTIONAL POLICY PROVISIONS

- ❑ Misstatement of age.
- ❑ Unpaid premiums.
- ❑ Insurance with other insurer.
- ❑ Cancellation.
- ❑ Change of occupation.
- ❑ Other insurance in this insurer.
- ❑ Conformity with state statutes.
- ❑ Relation of earnings to insurance.
- ❑ Illegal occupation.
- ❑ Intoxicants and narcotics.
- ❑ Insurance with other insurers.

MISSTATEMENT OF AGE

If an applicant misstates his / her age at the time they are applying for coverage, any benefit due them will be adjusted to reflect what would have been purchased had the correct age been stated in the first place.

UNPAID PREMIUMS

Should a claim become due and payable while a premium remains unpaid, the premium due will be subtracted from the claim amount due and the difference will be sent to the insured or beneficiary.

INSURANCE WITH OTHER INSURER

So as to avoid over insurance and if the company finds that there was other existing coverage for the same risk, the excess premiums will be refunded to the policy owner.

CANCELLATION

The company has the right to cancel the policy with 20 days written notice to the insured and the insured may cancel the policy following the expiration of the policy's original term.

CHANGE OF OCCUPATION

After a policy has been issued should the insured change to a more hazardous occupation that would require an increase in premium and the insurance company is not notified and a loss occurs, the benefit paid will be reduced. Should the opposite occur, and a loss occurs, a refund will be made to the insured for the excess premium

OTHER INSURANCE IN THIS INSURER

To avoid over insurance and limit a company's risk coverage written on one person is restricted to a maximum amount no matter how many separate policies the insured has. Premiums that have been applied to the excess coverage will be refunded to the insured or to their estate.

CONFORMITY WITH STATE STATUTES

Should any part of a policy conflict with state statutes in the state where the insured resides, the policy shall automatically amend itself to conform to statutory requirements.

RELATIONS OF EARNINGS TO INSURANCE

If at time of disability, monthly benefit amounts due exceed the insured's monthly earnings or the average of his earnings for the previous two years, the company is only liable for the amount that is proportionate to the insured's earnings under all such coverage.

ILLEGAL OCCUPATION

Policy benefits are not payable if the insured has a loss while committing a felony or being connected with a felony or participation in any illegal occupation.

INTOXICANTS AND NARCOTICS

Should the insured be under the influence of narcotics or intoxicated, unless such were administered on the advice of a physician the company is not liable for any losses.

FOCUS POINTS

POLICY PROVISIONS

1. The NAIC model calls for 12 required and 11 optional policy provisions.
2. Entire contract refers to the policy and all attached riders.
3. The period of incontestability is usually two years
4. Reinstatement permits a policy to be re-activated within certain specified conditions

5. Claim forms must be provided within 15 days of the time a company received.
6. Grace Period permits in most cases up to 31 days to make a delayed payment without penalty and the policy remaining in force.
7. Notice of claims must be made within 20 days or as soon as reasonably possible.
8. Payment of claim is usually made within 60 days.
9. Proof of loss must be submitted within 60 days.
10. Claim payments are made to a beneficiary or estate.
11. An insurer can request at their expense an autopsy.
12. Changes in beneficiaries can be made at any time unless an irrevocable beneficiary has been designated.

Essay Quiz;

Name the 11 optional policy provisions _____

CHAPTER NINE

THE BASICS OF THE POLICIES

UNDERSTANDING THE IMPORTANCE OF DISABILITY INCOME

If you had a machine that produced 15 crisp \$100.00 bills each month, how would you take care of it? Would you cover it? Would you oil it? Would you insure it? Of course you would! You are that money machine. You are the one that produces an income each month.

Disability income insurance is one of the most undersold and overlooked markets in the insurance business. Surveys taken tell us that 85%, yes, 85% of workers surveyed in companies, that employ 3 to 50 employees, have NO SHORT TERM OR LONG TERM DISABILITY. It has been said that 97 out of 100 American families would be bankrupt if they missed just THREE PAYCHECKS!

If you went to your doctor today and he said, " Well, the tests have come back and you need to go home and get in bed and stay flat on your back for 7 months because the illness you have requires this." Would you have a problem paying your bills? Some say "I have money in the bank" or "I have sick pay at work" or "My friends will support me" (That's the best of all of them. Well the truth is that the majority of us would be in serious financial trouble. The light company, phone company, Mortgage Company, and auto finance company could care less.

They want their money and ***NOW!***

POLICY ELIMINATION PERIOD

An important factor to consider here is how long would you be able to continue your present standard of living in the event of a total disability. That is how long can you wait before the company begins paying you benefits? This is called the policy elimination period.

The following elimination periods are available:

- 14 day (very rare and hard to find)
- 30 day
- 60 day
- 90 day
- 180 day
- 365 day

Obviously the policy elimination period has a great deal to do with the premium you will pay. The longer you wait, the less it costs. The shorter the wait the higher the cost.

You need to consider the following factors in determining your policy elimination period:

- How much liquidity of assets or savings do you have?
- Do you have a short-term disability policy at work?
- Do you have sick days accumulated holidays or bonus days at work that you may use?
- Do you have vacation time coming?
- Does your spouse have an income you can depend on?
- Do you have sources of unearned income from rentals, investments, dividends, interest and the like?
- Very carefully make a list of your fixed expenses and know exactly how long the above four factors can provide you an income.

Now you can intelligently determine the proper policy elimination period.

BENEFIT PERIOD

Another factor that affects the cost of your disability income policy is its benefit period. This is the period of time that benefits will be paid to you for total disability.

Typical benefit periods are as follows:

- ❑ One year
- ❑ Two years
- ❑ Five years
- ❑ Age 65
- ❑ Lifetime

The average disability lasts 9 to 18 months. However, depending on your occupation and the definition of your occupation, the benefit period is a major consideration. For example, if you are a plastic surgeon, losing a hand is a major disability and you certainly would want to have an age 65 or lifetime benefit period. If however, you are a tow truck driver, a one or two years benefit period might be just fine.

HOW IS A DISABILITY POLICY RENEWABLE?

There are two types of renewal provisions in disability plans.

- Non-cancelable
- Guaranteed Renewable

DEFINITION OF NON-CANCELABLE

This type is the most favorable to you and the one that the underwriters look at the closest. So long as you pay your premiums on time to a pre-determined date, usually age 65.

The company **CANNOT**:

- Cancel the policy.
- Change any provisions.
- Add any riders that restrict coverage.
- Add any changes to the policy.
- Raise the premiums.

DEFINITION OF GUARANTEED RENEWABLE

A disability policy may be Guaranteed Renewable Only. This means that the company CANNOT do any of the above five EXCEPT number 5. The company CAN raise the premiums but you cannot be singled out. The company must raise the premium for all that are either in that class or that type of policy contract.

WHAT HAPPENS WHEN YOU TURN 65?

In order to keep the policy beyond age 65, you must:

- ❑ Be employed full-time under their definition.
- ❑ Pay your premiums on time.

HOW IMPORTANT IS THE DEFINITION OF TOTAL DISABILITY

This definition determines if you will get paid or not when a claim is filed. It is very important.

Basically, the definition of ***TOTAL DISABILITY IS AS FOLLOWS:***

- ❑ YOU CANNOT OR ARE UNABLE TO WORK AT ONE OR MORE OF THE IMPORTANT DUTIES OF YOUR REGULAR JOB.
- ❑ YOU ARE UNDER THE CARE OF A QUALIFIED AND LICENSED PHYSICIAN.

OCCUPATIONS

One of the most important considerations in issuing a disability policy is the insured's occupation. Obviously, the more hazardous your job, the higher the premium because of the inherent risks factors.

Therefore, companies take a close look at the following categories regarding your occupation:

- Do you travel a lot in your job?

- What kinds of materials, machines, or tools do you use?
- What industry is your company engaged in?
- Do you manage others?
- Is your job seasonal in nature?
- Are you prone to being laid off or having your hours shortened?

OCCUPATIONAL CLASSIFICATIONS

Disability policies can use a class grouping or an alphabetical grouping for occupations.

The five most common are:

- Class One or AAAA.
- Class Two or AAA.
- Class Three or AA.
- Class Four or A
- Class Five or B.

CLASS ONE OR AAAA.

Occupations commonly found here are the ones with favorable claims experience such as CPA's, Dentists, Doctors, Vets, etc.

CLASS TWO OR AAA.

Occupations in this group are typically managerial technical professional and executive types who's duties are generally restricted to the office.

CLASS THREE OR AA.

Occupations here are comprised of supervisors of performing employees but not those that do the actual operations. Merchants, Salespeople, Store Managers are a few examples.

CLASS FOUR OR A.

Here you will find skilled labor type of occupations such as home construction and small construction machines to name a few.

CLASS FIVE OR B.

Here we find the most hazardous of the occupational classifications and the most difficult to insure. A Motorcycle Police Officer, Bricklayer, or Welder is prime examples.

INCOME REQUIREMENT

This area is one that is very strictly underwritten in that companies do not want to permit you to earn more income while disabled than you would while working. Obviously, this situation would cultivate false claims and malingering disabilities. Therefore, companies place a percentage of monthly benefits to your monthly-earned income. Typically, companies will issue a monthly benefit equal to from 40 to 70% of your earned income. For example, if you earn \$3,000 per month, you can expect a company to give you a monthly benefit of from \$1,200 (40% of \$3,000) to \$2,100 (70% of \$3,000) or any amount in between.

Companies are looking for "earned income" which can best be defined as income for which you must sweat. Companies also look at "unearned income" such as rental income, royalties, investments, or dividends. Since this is income that would normally continue even if you were disabled it is generally not considered in the percentage formula and in some cases, it may even reduce the amount the company is willing to issue as benefit.

WHAT TYPES OF OCCUPATION DEFINITIONS ARE THERE?

- Your regular occupation.
- A limited regular occupation.
- Your regular occupation (Not working).
- Non-occupation

YOUR REGULAR OCCUPATION

This definition is the best of the choices. However, it usually applies only to insured's that are in highly professional positions such as dentists, lawyers and doctors. This definition covers the insured's "usual work" and a claim will be paid when the insured satisfies this stipulation.

A LIMITED REGULAR OCCUPATION

This is the second best of the choices. The major difference is that the insured would not be considered disabled for the full benefit period. For example if the benefit period were 5 years, the policy may cover you for 3 of those years under the regular occupation definition.

However, after the 3 years definition has been satisfied the policy would contain an additional condition the last 2 years of the benefit period and it may then say:

- ❑ Coverage will continue if the insured is not working in a reasonable occupation or if the insured is unable to work in a reasonable occupation

YOUR REGULAR OCCUPATION (NOT WORKING)

In order to qualify for disability benefits under this definition you must be:

- ❑ Unable to do the substantial and material duties of your job AND not work in a reasonable occupation.

NON-OCCUPATION

Rather than specially address an occupation, this definition says that you are totally disabled if,

- ❑ You are unable to work at any job for which you are reasonably suited for by training, education or experience.

WAIVER OF PREMIUM

This provision is usually part of all disability contracts. It states that if the insured is disabled more than 6 months (some may be 90 days) the premiums are waived until the insured goes back to work and no longer disabled or the benefit period expires. Some policies also refund the premiums you paid during the 6 month (or 90 day) period while you were waiting for the waiver provision to start.

EXCLUSIONS

There are three that commonly appear in most disability policies. They are:

- ❑ Self inflicted injury.
- ❑ Pregnancy.
- ❑ War

Some companies have removed the pregnancy exclusion in order to be more attractive to the female market.

GRACE PERIOD

The grace period is defined as the period of time beyond the due date that you may pay the premium without the policy lapsing. This is 31 days in most disability policies. During the grace period, the policy stays in force so long as you pay the premium that is due before the end of the 31st day.

CONTESTABILITY

Disability policies contain a period of contestability that is usually two years. It should be noted that some policies exclude periods of disability during the two years. During the period of contestability the insurance company is given time to determine if any misstatements were made so that they can have the option of either rewriting the policy, or canceling it. After two years, there is nothing that can be done if misstatements are discovered.

CHAPTER TEN

DISABILITY POLICY OPTIONS

CUSTOMIZING YOUR POLICY

Flexibility is one of disability income's strong suits in that you are able to add a lot of bells and whistles or options to customize your disability policy.

For example, the following are common "options" that are available:

- ❑ Cost of living.
- ❑ Future increase of monthly benefit.
- ❑ Hospital confinement.
- ❑ Life extension.
- ❑ Social Security rider.
- ❑ Cash back option.

COST OF LIVING

This is an excellent option considering today's inflationary trend. This option permits the insured to increase his monthly income benefit based upon certain factors. The increase may be tied to the Consumer Price Index or it can be guaranteed to specific limits. Some can have a cap as to the maximum. Others have no cap and allow you to continue increasing your coverage until you reach age 65.

FUTURE INCREASE OF MONTHLY BENEFIT

This option allows you to increase your monthly benefit without evidence of insurability on specific future dates.

Examples of times in which you may increase your monthly benefit are:

- ❑ Every fourth policy year anniversary up to a specific number or amount.
- ❑ The birth of a child.
- ❑ Marriage.
- ❑ Purchasing a new home.

Typically, the policy states that when any of the above events take place, you may increase your monthly benefit a specific amount each time such as \$300 or \$400 per month up to a final monthly maximum.

HOSPITAL CONFINEMENT

This option permits you to purchase a specific daily benefit in addition to your regular monthly disability income benefit. This option requires that you are admitted to the hospital as an "Inpatient" and during that time, the policy pays a daily benefit of \$25 to \$200 for each day that you are in the hospital

LIFE EXTENSION

This option is available when the basic policy has an age 65-benefit period. It extends the benefit period for total disability to the lifetime of the insured in ONE of the four following ways:

1. Lifetime benefits are paid if total disability begins before age 50, 55, or 60.
2. Lifetime benefits are paid if total disability before a specific age, but at a reduced percentage of the policies monthly income benefits. An example of this might be that you are 60 years of age and become totally disabled, the full monthly benefit will be paid

to you until you are 65, then at age 65, the lifetime extension is reduced to 50%.

3. Lifetime benefits are paid if an ACCEDENT causes total disability before age 65. This does not include illness and benefits would cease at age 65 with no lifetime extension.
4. Lifetime benefits are paid if total disability occurs before age 65 and there are absolutely no other restrictions as to accident or sickness, age of onset of disability prior to age 65, or reduction in benefit. Obviously, this is the best of the four, and also the most expensive.

SOCIAL SECURITY RIDER

Here a benefit is paid to you if Social Security does not pay benefits. This is an excellent rider for the money in that Social Security is the most difficult disability income benefit to qualify for. Social Security has been known to deny in excess of 65% of all claims for benefits.

Basically this rider stipulates that you will receive an additional monthly benefit above and beyond your basic monthly benefit if Social Security benefits are denied. If however, Social Security does approve benefits, then the insurance company will not pay this additional monthly benefit. Another way in which this option works is that your basic monthly benefit WELL BE REDUCED by any amount Social Security pays.

CASH BACK OPTION

Many people feel that this option is expensive and impractical. One of their major complaints is that their money does not earn any interest. An insurance company charges an additional premium, which can be very substantial for the cash back option.

The two most common cash back options are as follows:

- ❑ The company will return to you at age 65 all premiums paid less any benefits received. In the event benefits received exceed the premiums you have paid to age 65, there is no return of your premium. Some companies will permit you to drop the cash back option and reduce your premium accordingly, should you ever reach the point that benefits paid exceed your premiums and there is no way for you to get your premiums back. However, most

companies continue charging you the additional premiums for the cash back option even when benefits paid exceed your premiums.

- The company will review your policy every ten years (rather than waiting to age 65) and return 80% of all premiums paid, less any benefits received. You can then use this return or premium to pay future premiums. Obviously most people will find other uses for the money.

CHAPTER ELEVEN

OVERHEAD EXPENSE POLICIES FOR BUSINESS

BUSINESS OVERHEAD POLICY

If you own a business, one of the major disasters you could face is the owner not being on the premises to run the business. A business overhead policy can help keep the business open until the owner is able to return to work. Many businesses are dependent upon the owner's knowledge, skilled profession, or just plain good within dealing with customers or bank connections. Obviously, their absence could pose big problems in these areas. This is especially true when the owner is the key employee or major factor in the success of the business.

Conversely, there are business owners that do not play major roles in the operation of their business but depend on others to do what is necessary to produce income for the company.

ELIMINATION PERIODS

Common elimination periods for business overhead policies are as follows:

- ❑ 30 day
- ❑ 60 day
- ❑ 90 day

The most common of the elimination periods is the 30-day in those business owners do not have sufficient funds to cover business expenses for a long period of time.

BENEFIT PERIOD

Common benefit periods for business overhead policies are as follows:

- ❑ 12 months
- ❑ 15 months
- ❑ 18 months
- ❑ 24 months

Typically, you must realize that if the business owner does not return because of a total disability after 24 months their return at all is certainly doubtful.

MONTHLY BENEFIT

Monthly benefit considerations made here are:

- ❑ The type of business.
- ❑ Owner's occupation.
- ❑ Insured's portion of the work.
- ❑ Employee's portion of the work.
- ❑ Amount of loss of income.
- ❑ The company's current expenses.

COVERED EXPENSES

There are many expenses in running a business and not all can be covered with a business overhead expense policy.

The following are some of the more common of the covered expenses:

- ❑ Rent
- ❑ Utilities such as

- ❑ Water
- ❑ Heat
- ❑ Electricity
- ❑ Telephone
- ❑ Telephone Answering Service
- ❑ Employee's salaries
- ❑ Employee fringe benefits
- ❑ Payroll Taxes
 - ❑ FICA (Social Security & Medicare)
 - ❑ FUTA (Federal Unemployment Tax Act)
 - ❑ SUTA (State Unemployment Tax Act)
- ❑ Professional or Association Dues
- ❑ Accounting fees
- ❑ Premiums for business insurance
- ❑ Postage
- ❑ Stationary and Supplies
- ❑ Furniture and equipment depreciation
- ❑ Janitorial Service and maintenance
- ❑ Laundry

EXPENSES NOT COVERED

It is very important that the policy owner understands **WHAT IS NOT COVERED** so that there are no misunderstandings or disputes at the time of claim.

The following are usually **NOT COVERED**:

- ❑ Purchases of equipment or furniture.
- ❑ Salaries, draws, commissions, fees, or any other monies due the owner. (The owner covers these expenses with a personal disability income plan).
- ❑ Payments made towards debts.

DISABILITY INSURANCE FOR A KEY EMPLOYEE

Often times an employee of the company is a key ingredient to its success. Should he / she become sick or hurt, the financial consequences to the company could be severe. A disability insurance plan for this key employee is the answer. The company purchases the disability policy and the company becomes its beneficiary. Should the key employee become disabled, the company is then reimbursed for the expected income loss caused by his / her absence. As a rule, the benefit period is for 6,12,or 18 months.

CHAPTER TWELVE

TAXES

You have heard two things are certain; death and taxes. The role of thumb for Uncle Sam is pay him now or pay him later.

When writing disability income in the business market the tax laws depend upon the type of business involved. You should therefore be familiar with the following types of businesses:

CORPORATION

This is an entity granted a legal charter for a body of persons that are recognized as separate entities authorized by law. All business matters are done in the name_of the corporation and the corporations, not the stockholders, are responsible for any liabilities or obligations.

SOLE PROPRIETORSHIP

The business is fully owned by one person and is not incorporated. In most cases, this person is the owner or manager and they are personally responsible for liabilities and obligations for both business and personal assets.

PARTNERSHIP

Here there are usually two or more people who join together as principals of a legal association. Each of the partners is responsible

and personally liable for the obligations of the partnership with personal assets as well as their investment

TAXES ON PERSONAL DISABILITY INCOME PLANS

Premiums paid for personal disability income plans are not tax deducted. The good news is that regardless of how much you receive while totally disabled under a personal disability plan, all income is received 100% tax-free. A business owner for example, could insure himself / herself under a "Tax-favored sick-pay plan" and have it construed to be personally purchased. Here again the benefits are completely tax free because the business owner is not considered an employee and the premiums cannot be tax deducted.

SICK-PAY PLAN FOR KEY EMPLOYEES

The premiums are completely tax deductible as a necessary business expense for disability purchased on key employees. As a business owner, you are faced with the possibility of continuing a key person's salary when they are disabled. This plan solves that problem

TAXES ON BONUSES FOR EXECUTIVES

Executive Bonus is a simple way to insure tax-free benefits. The bonus can be deductible to the business owner as compensation to the executive. The business owner merely pays a bonus to the executive equal to the amount of the premium and writes it off as a business expense. The executive must report this bonus as ordinary income and pay the appropriate income tax disability benefits to the executive are received tax-free.

TAXES ON OVERHEAD EXPENSE POLICIES

Since the business owns the policy and the premiums are deducted as a business expense, the income from the policy when paid to a disabled owner are taxable. Since, however, the benefits are being used to pay business expenses there is obviously an offset.

CHAPTER THIRTEEN

DISABILITY UNDERWRITING

Contrary to popular belief, the "underwriter" is not just a home office position. Many companies place a lot of responsibility on the good judgement of the agent in the field when it comes to insuring a disability risk. As an agent in the field, you have the upper hand in that you are not merely dealing with the information contained on the application, but are in fact, seeing and talking to the potential insured.

Underwriters use the following details to determine the risk factors in writing a disability policy.

- ❑ Date of birth.
- ❑ Occupational rating.
- ❑ Address.
- ❑ Gender.
- ❑ Earned Income.
- ❑ Net Worth.
- ❑ Expenses.
- ❑ Unearned Income.
- ❑ Benefits applied for.
- ❑ Current coverage.
- ❑ Medical History.
- ❑ Family History.
- ❑ Present physical condition.

- ❑ Hobbies.
- ❑ Moral Character.

DEFINITION OF UNDERWRITING

Underwriters can be compared to judges in that they gather "all the evidence" so to speak, concerning an individual and try to judge or determine to issue that individual a disability income plan. Disability underwriting and life underwriting have many different concerns. There are many conditions a potential insured can have that are not life threatening but are certainly possible disability income claims. For example, bad knee or back or shoulder injury while not life threatening, certainly become future disability claims.

DEFINITION OF MEDICAL UNDERWRITING

Medical underwriting is done two ways: First, in the field with the agent and, Second, with questions on the application.

The following areas are studied very carefully in the medical underwriting process:

- ❑ Parts of the body that is affected.
- ❑ Symptoms.
- ❑ Date of onset.
- ❑ Severity of symptoms.
- ❑ Frequency.
- ❑ Duration.
- ❑ Cause.
- ❑ Time off work.
- ❑ Diagnostics.
- ❑ Kind of treatment.
- ❑ Names of all medical practitioners consulted.

IMPORTANCE OF MEDICAL EXAMINATIONS

The companies print and publish what are referred to as non-medical limits". In other words, there are certain points at which a medical exam is required.

The following factors are taken into consideration and the company determines whether or not they want a physical exam or other test.

- ❑ Occupational classification.
- ❑ Age of applicant.
- ❑ Amount applied for.
- ❑ Benefit period applied for.

FOR EXAMPLE -

If you have a non-hazardous occupational class, are over age 60, and request a long benefit period, you will probably exceed the non-medical limit. Conversely, you could have a hazardous occupation with a short benefit period and not be required to take an exam.

UNDERWRITING SUBSTANDARD POLICIES

Not every applicant can be given a standard policy. There are many factors that cause an applicant to be considered substandard.

Some of them are:

- ❑ Current status of health.
- ❑ Age.
- ❑ Occupational rating.
- ❑ Pre-existing conditions.
- ❑ Sports or hobbies.

Rather than completely deny coverage, some companies are willing to make adjustments and issue a substandard policy.

Examples of these are as follows:

- ❑ Shorten the benefit period.
- ❑ Lengthen the elimination period.
- ❑ Issue a rider that excludes or limits coverage in certain areas.
- ❑ Charge an extra premium above and beyond the standard premium.
- ❑ Issue an exclusion rider for a qualified condition.

FINANCIAL UNDERWRITING OF DISABILITY PLANS

Before a company is willing to offer a specific amount of coverage, they will need to know all sources of the applicant's income.

This financial picture is very important some of the factors considered are as follows:

- ❑ Insured adjusted gross income.
- ❑ Existing disability policies.
- ❑ Unearned Income.
- ❑ New worth.

CHAPTER FOURTEEN

DISABILITY CLAIMS

Any time company sells disability income insurance, it knows that part of the premium dollars taken in are going to be paid out in claims. Most companies make every effort to pay claims fairly and promptly. However, they also know that it is the company's obligation to be certain that unjust claims are not paid. You should be aware of exactly what method your company uses in claims processing.

FOR EXAMPLE:

- Some companies underwrite the application.
- Some companies underwrite the claim.

When the client becomes disabled and has a loss of income and needs that money to pay his / her obligations, they have a very short attention span when it comes to claims. Companies that underwrite the application certainly have the advantage over those that underwrite the claim. Most agents prefer companies that underwrite the application so that there are no problems or misunderstandings at time of claim.

Obviously, the claim form is very important as an agent, your role is to bring the form to the insured and assist them in completing it. Caution is given here in that you should only assist the insured and you should never complete the form yourself. The claim form will give the company the information necessary to process the claim. Remember, the quicker the claim begins, the quicker the claim can be paid.

OTHER FACTORS FOR CLAIMS

Some confusion lies as to when one can apply for benefits, if the disability income policy contains a 30 day waiting period. The insured is eligible for benefits on the 31st day. However the agent must realize that his client may not see the first check for over 60 days. Companies pay claims only as earned. In other words, they will not accept

estimates that a client may be off work for six months and therefore, send a check for six months in the future.

As a rule, if an insured is in fact, not going to return to work for a period of six or eight months, according to the physician's estimates, the insured must submit an up to date claim form every 30 days.

Remember one of the primary requirements of the insurance company for continuation of benefits is that the insured be currently under the care of a qualified licensed physician.

The company also reserves the right to request periodic physical examinations on the insured to ascertain whether or not the condition that has caused total disability still applies. In most cases, the company pays for the physical examination and in almost all cases, the company, not the insured, picks the doctor to do the examination.

In conclusion, disability income is one of the most important policies you can have because it protects your most valuable asset the ability to earn an income for your family.

CHAPTER 15

THE AGENCY RELATIONSHIP

A new agent concerned with the every day requirements of his company often forgets the legal and ethical requirements of his new undertaking. These expectations fall under an area known as AGENCY.

Agency is a legal term that describes the relationship between two parties. The first party (the principal) authorizes the second party (the agent) to perform certain legally binding acts on behalf of the principal.

In the case of an agent and his employing firm this relationship exists because the agent is acting on behalf of his insurance company and entering into legal contracts on behalf of his firm with consumers. The agent's ethical behavior is of utmost concern in carrying out the principal's instructions.

Agents are often charged by their principals with the actions of collecting premiums, entering into contractual agreements on behalf of their principals, making representations on behalf of their principals and in general promoting the products offered by their principals. The law holds the agent as responsible for his or her behaviors as it holds the principal for the same.

By establishing an agency relationship the company is entrusting the agent to represent its' every interest in a transaction.

HOW IS AGENCY CREATED?

Agency can be created in three manners:

- ❑ Appointment
- ❑ Estoppel
- ❑ Ratification

AGENCY BY APPOINTMENT

Agency by appointment results by written contract between the principal and the agent. The contract specifically outlines the duties and obligations of each and often carries specific direction and duties.

AGENCY BY ESTOPPEL

Agency by Estoppel is an implied agency. When a principal allows an agent to behave in such a manner that a third party might interpret the agent's actions to be those of the principal than an agency by Estoppel is established between the principal and the agent.

Agency by Estoppel requires three elements in order to be established. These three elements are:

- The principal must act in a manner that allows the agent to lead a third party to believe that a relationship exists between the agent and the principal.
- An innocent third party must be misled by the principal's actions.
- The third party must be harmed by the principal's behavior.

An example of this might be where an agent's contractual commitment to a principle has been terminated and the agent continues to use the business cards and contracts of his principal and binds consumers to these agreements. By failing to confiscate their forms and identification documents from their prior agent, should a third party be harmed by the actions of the agent, the company (the principal) would be liable for the actions of the prior agent. This does not free the agent from being held accountable from unethical conduct.

AGENCY BY RATIFICATION

Agency by ratification occurs when an individual represents to be authorized by a Principal but in reality is not. When the principal eventually authorizes the actions of the agent, he, the principal has now ratified the authority and thus binding the commitments of that agent.

An example of this might be where an agent knows that he can book a certain type of coverage with an insurance company, thus leads the client to believe that he already has a relationship with that firm and books the coverage. Later on the agent presents

the contract to the insurance company and the company accepts the coverage and thus ratifies the agent's authority. The ratification can be solely limited to that transaction or extended to all future transactions. Failing to notify the insured that the authority is strictly transactional would create the potential of an agency by Estoppel with the insured.

HOW THE AUTHORITY OF AN AGENT IS CREATED

The authority of an agent is created by contract. This is how an insurer grants an agent the right to act on their behalf in their relationship with a third party, the insured.

The power or authority of an agent is defined in the contractual agreement between himself or herself and the principal. The ranges of authority vary and can be either very broad or very limited. The authority granted the agent must be very specific as to avoid an agent acting on behalf of the principal in matters not authorized. Since the agent acts on behalf of the principal the legal and ethical repercussions to the principal can be far-reaching and extremely libelous if the authority is not well defined.

The agent's authority to act on behalf of the principal is created in three different ways:

- ❑ expressed consent.
- ❑ implied consent.
- ❑ apparent consent.

EXPRESSED CONSENT

Expressed consent is usually granted either verbally or in writing and spells out what an agent can or cannot do on behalf of the principal. This form of consent is usually granted in the agency contract and often spells out the agent's ability to solicit, initiate applications and collect the initial premiums due on a new policy.

IMPLIED CONSENT

Implied Consent is granted as a result of those actions, which must be taken to carry out the authority granted to an agent in expressed consent. This authority is granted to an agent in a non-written or verbalized manner. In other words these are actions that must be carried out in order to help achieve the end goal of the principal in employing the agent.

An example of this might be the “binding” authority an agent has prior to the issuance of an actual policy.

APPARENT CONSENT

This form of authority occurs whenever a principal permits an agent to act on their behalf without either expressed or implied authority.

An example of this type of authority would be where an agent has territorial restrictions by the principal and yet the principal accepts business from the agent outside these boundaries, then by accepting this business the principal has established apparent consent of the agent’s actions. The agent’s authority is in most cases limited and even though he or she may make decisions on behalf of the principal often times these decisions have limitations and are subject to the principal’s review.

Examples of limitations on an agent’s authority are:

- the inability to adjust premium rates,
- the final decision to accept the risk involved
- the inability to waive exclusions (unless specifically authorized)

For an agent to step beyond the authority granted creates serious legal and ethical issues with both the principal and the consumer.

Because an agent is licensed by the state his or her conduct is monitored not only in respect to meeting obligations with the employing principal but also in maintaining an honest and ethical relationship with the consumer as the insured.

In essence the agent is held to the highest level of trust and ethical conduct by the principal, the consumer and the state licensing authority.

The Agent thus becomes a fiduciary.

THE AGENT AS A FIDUCIARY

A fiduciary is an individual whose position or responsibility involves having the highest degree of trust and confidence. Trustees of estates, guardians of individuals, executors are all individuals that fall in this category. An agent in the same manner when he

under takes an employment with an insurer is held to the same degree of trust and fair play and responsibility.

An agent owes his principal:

- ❑ Loyalty
- ❑ Skill
- ❑ Disclosure
- ❑ Timeliness
- ❑ Accountability of funds
- ❑ Sole interest
- ❑ Diligence in Solicitation of Business
- ❑ Competitive Fair Play

LOYALTY

An agent must always act on behalf of the insurer's best interest and must put the insurer's needs even ahead of his or her own needs. This is the role a fiduciary takes in entering into an agreement with a principal.

An agent unless authorized to do so cannot represent more than the interest of one principal. Often independent agents and brokers represent the interest of more than one insurer. This is proper and ethical as long as there is full knowledge and consent of all the parties.

An agent must stay within the confines and conditions of his or her agency contract with the principal. An agent cannot receive personal financial gain other than that specified in his or her agency agreement.

SKILL AND CARE

In representing his principal the agent has been entrusted with the ability to handle his or her principal's needs in a skillful and diligent manner. The agent must use every skill at his or her disposal to make sure that the principal's goals are reached in the most effective and efficient manner possible. The agent represents the company to the public. And, therefore, must present that principal to the highest competency; thus, if

the agent should encounter a consumer demand that he is not skilled to handle, he or she should refer the client out, in order to insure the principal's best representation.

DISCLOSURE

It is the agent's obligation to the insurer to make sure that all questions on applications are answered truthfully and nothing is omitted. To induce the insurer to enter into a risk that is not sound is both unethical and in conflict with the agent's fiduciary obligation to the insurer.

Full disclosure is critical in both the application and claim handling process.

TIMELINESS

Submitting all paperwork on a timely basis is imperative to the principal's business success and risk. The insurer has obligations to the consumer based on time schedules. Not meeting these obligations due to delays caused by an agent not acting in an expedient manner causes the company to be at risk for longer periods of time in the case of an insured that will be denied, or delays the underwriting procedure for one that will be accepted

ACCOUNTABILITY OF FUNDS

Under the law delivering premiums to an agent is the same as delivering them to the insurer. Therefore delivering those funds to the insurer by the agent as quickly as possible is of utmost importance.

Premiums collected from the insured parties are usually held in PREMIUM FUNDS TRUST ACCOUNTS for no more than 90 days or other date specified in the agent's contract with the insurer. Funds held by agents are required to be held in these special trust accounts by most states. In submitting funds from these accounts to the insurer it is most commonly permitted for agents or brokers to retain their portions of commissions earned prior to submitting the premiums to the insurer.

SOLE INTEREST

An agent must act in all transactions as to avoid any potential conflict of interest between himself or herself, the insurer or the insured. An agent has an obligation to the

insurer to represent the product in a skillful and honest manner. Should there be any misrepresentation wherein the insured makes a decision based on the misrepresentation, intentional or otherwise, the agent would be liable for losses to either the insurer or the insured or both

In the event an agent receives compensation in a transaction for performing related services in the same transaction the insurer must be made aware of this compensation and must in no way conflict with the agent's contractual obligation with the principal.

DELIGENCE IN SOLICITATION OF BUSINESS

It is the obligation of an agent to solicit business that represents the risk element that His insurer is willing to take. To solicit higher risk business and omit or alter the application in an effort to conceal the risk factor is unethical and not in keeping with the fiduciary responsibility owed the principal.

COMPETATIVE FAIR PLAY

Ethically in the insurance industry it is accepted practice that when the issue of a competing firm is brought up that it is in the best interest of the industry not to defame a competitor but stick to issues of one product verses another.

CHAPTER 17

CAPTIVE AGENTS VS INDEPENDENT AGENTS

CAPTIVE AGENT

An agent who has signed an exclusive contract with one or more companies is considered a captive agent. He must represent the interest of those companies as their fiduciary in the highest and most reputable manner.

It would be unethical for this type of agent to represent more than one insurance company selling the same or similar policies.

The insurer owns and maintains control of all accounts serviced by the agent and in return the agent is paid a salary and /or commissions.

The agent has an obligation to disclose to the insurer his or her interest in any similar business or service that he renders regardless of whether he or she receives compensation. It is then up to the principal to determine whether there exists a conflict of interest.

INDEPENDENT AGENTS

Independent agents most often represent several companies and are paid on commission.

The agents own all of the clients and typically shop the best premium for that insured.

If an independent agent severs his relationship with a company the agent may rewrite the insured with a different company, provided that, it is with the consent and permission of the insured.

Because independent agents must often meet quotas by insurance companies in order to maintain their writing ability with that company, the ethical issues this type of agent

often faces, is the dilemma of getting the best deal for his consumer, verses meeting his or her quota, or perhaps receiving the highest commission.

To avoid these conflicts and potential ethical violations, the independent agent must follow the guidelines set forth for DUAL AGENCY.

Under these guidelines the agent represents:

- his or her client only during the process of helping the client select the insurance plan best suited to the client's needs. It is up to the agent to see that the insurance policy is written properly to meet the clients needs and intent.
- the insurance company when the insurance is being applied for and when it is in process of being underwritten, in record keeping, in claims settlement or other insurer related activities.

Dual agency when practiced ethically can serve both the insurer and the client without conflict.

CHAPTER 18

PRINCIPAL'S OBLIGATIONS TO THE AGENT

Because the principal is obligated and responsible for the actions of his agents it is imperative that the principal chooses individuals of the highest caliber of ethical conduct.

The obligations of both the principal and agent are spelled out in an employment agreement

The principal has three major duties to the agent:

- Employment
- Compensation
- Indemnification

THE EMPLOYMENT AGREEMENT

The employment agreements covers the following elements:

- Length of time
- Minimum production standards
- Lines of business that may be written
- Method of compensation
- Principal's recourse for non performance

THE PRINCIPAL'S OBLIGATION OF COMPENSATION

In exchange for representation the principal compensates the agent based on the terms of the employment agreement. Compensation is broken down depending on the nature of the business and whether it is new business or renewal business.

The most common break down is as follows:

- Different rates for different lines of insurance.
- Higher rate of commission on new business.
- Lower rate of commission on renewal business.

Because of this structure sometimes agents shift policyholders from one company to another at renewal time. An ethical agent must never do this at the expense of the insured.

INDEMNIFICATION OF AGENT

Unless the agent is found guilty of breach of duty or lacking in due diligence, the principal indemnifies the agent from all costs and claims made against him in the carrying out of his duties under his agency relationship with the principal.

CHAPTER 19

BROKER VS AGENT

A broker legally represents the insured. And acts as an independent contractor on behalf of his principal, the insured

The broker's role is to seek out the best he can find for his client, the insured, and represent that client's best interest. Although he receives compensation from the insurer

the amount of compensation should not become an ethical issue by serving his needs ahead of his principal's needs.

The exception to the representation rule previously outlined, is when a broker is collecting a premium from the insured, he, the broker becomes an agent of the insurer in the delivery of that money.

Because the broker is the agent for the insured, he many times does not have binding power on behalf of the insurer.

Much like an agent who has certain ethical obligations to both the insurer and the insured.

The broker also has obligations to the insurer even though his client is the insured.

BROKER'S OBLIGATIONS TO THE INSURER

The obligations a broker has to the insurer include:

- Disclosure of all pertinent information
- Carrying out all obligations in a skill full and diligent manner
- Seeking out quality business

- Competing fairly and ethically
- Acting promptly and diligently

Without doubt both agents and brokers will continuously face the issues of self-preservation and serving their principals needs.

This ever-challenging conflict must be met with the utmost of integrity in order to serve both the insurer and the insured.

Falling to meet this obligation in this fashion can only result in a potential law suit and or Disciplinary Action.

CHAPTER 5

CODE OF ETHICS

Independent Insurance Agents of America believe in the insurance business and its future, and that the Independent Insurance Agent is the instrument through which insurance reaches its maximum benefit to society and attains its most effective distribution.

I will do my part to uphold and build the Independent Agency System, which has developed insurance to its present fundamental place in the economic fabric of our nation. To my fellow members of the Independent Insurance Agents of America, I pledge myself always to support right principles and oppose bad practices in the business.

I believe that these three have their distinct rights in our business: first, the Public; second, the Insurance Companies, and third the Independent Insurance Agents, and that the rights of the Public are paramount.

To the public

I regard the insurance business as an honorable occupation and believe that it affords me a distinct opportunity to serve society.

I will strive to render the full measure of service that would be expected from an Independent Insurance Agent.

I will analyze the insurance needs of my clients, and to the best of my ability, recommend the coverage to suit those needs.

I will endeavor to provide the public with a better understanding of insurance.

I will work with the national, state, and local authorities to heighten safety and reduce loss in my community.

I will take an active part in the recognized civic, charitable, and philanthropic movements, which contribute, to the public good of my community.

To the companies

I will respect the authority vested in me to act on their behalf.

I will use care in the selection of risky, and do my utmost to merit the confidence of my companies by providing them with the fullest creditable information for effective underwriting, nor will withhold information that may be detrimental to my companies' sound risk taking.

I will expect my companies to give to me the same fair treatment that I give to them.

To fellow members

I pledge myself to maintain friendly relations with other agencies in my community. I will compete with them on an honorable and fair basis, make no false statements, or any misrepresentation or emission of facts.

I will adhere to a strict observance of all insurance laws relative to the conduct of my business.

I will work with my fellow Independent Insurance Agents for the betterment of the insurance business.

Realizing that only by unselfish service can the insurance industry have the public confidence it merits, I will at all times seek to elevate the standards of my occupation by governing all my business and community relations in accordance with the provisions of this Code and by inspiring others to do likewise.

*American Institute for Chartered Property and Casualty Underwriters
Code of Professional Ethics*

Canons and Rules

Canon 1

CPCUs Should Endeavor at All Times to Place the Public Interest Above Their Own.

Rules of Professional Conduct

- R1.1 A CPCU has a duty to understand and abide by all *Rules* of conduct, which are prescribed in the Code of Professional Ethics of the American Institute.
- R 1.2 A CPCU shall not advocate, sanction, participate in, cause to be accomplished, otherwise carry out through another, or condone any act which the CPCU is prohibited from performing by the *Rules* of this *Code*.

Canon 2

CPCUs Should Seek Continually to Maintain and Improve Their Professional Knowledge, Skills, and Competence.

Rules of Professional Conduct

R2.1 A CPCU shall keep informed on those technical matters that are essential to the maintenance of the CPCU's professional competence in insurance, risk management, or related fields.

Canon 3

CPCUs Should Obey All Laws and Regulations, and Should Avoid Any Conduct or Activity Which Would Cause Unjust Harm to Others.

Rules of Professional Conduct

R3.1 In the conduct of business or professional activities, a CPCU shall not engage in any act or omission of a dishonest, deceitful, or fraudulent nature.

R3.2 A CPCU shall not allow the pursuit of financial gain or other personal benefit to interfere with the exercise of sound professional judgment and skills.

R3.3 A CPCU will be subject to disciplinary action for the violation of any law or regulation, to the extent that such violation suggests the likelihood of professional misconduct in the future.

Canon 4

CPCUs Should Be Diligent in the Performance of Their Occupational Duties and Should Continually Strive to Improve the Functioning of the Insurance Mechanism.

Rules of Professional Conduct

R4.1 A CPCU shall competently and consistently discharge his or her occupational duties.

R4.2 A CPCU shall support efforts to effect such improvements in claims settlement, contract design, investment, marketing, pricing, reinsurance, safety engineering, underwriting, and other insurance operations as will both inure to the benefit of the public and improve the overall efficiency with which the insurance mechanism functions.

Canon 5

CPCUs Should Assist in Maintaining and Raising Professional Standards in the Insurance Business.

Rules of Professional Conduct

- R5.1 A CPCU shall support personnel policies and practices which will attract qualified individuals to the insurance business, provide them with ample and equal opportunities for advancement, and encourage them to aspire to the highest levels of professional competence and achievement.
- R5.2 A CPCU shall encourage and assist qualified individuals who wish to pursue CPCU or other studies, which will enhance their professional competence.
- R5.3 A CPCU shall support the development, improvement, and enforcement of such laws, regulations, and codes as will foster competence and ethical conduct on the part of all insurance practitioners and inure to the benefit of the public.
- R5.4 A CPCU shall not withhold information or assistance officially requested by appropriate regulatory authorities who are investigating or prosecuting any alleged violation of the laws or regulations governing the qualifications or conduct of insurance practitioners.

Canon 6

CPCUs Should Strive to Establish and Maintain Dignified and Honorable Relationships with Those Whom They Serve, with Fellow Insurance Practitioners, and with Members of Other Professions.

Rules of Professional Conduct

- R6.1 A CPCU shall keep informed on the legal limitations imposed upon the scope of his or her professional activities.
- R6.2 A CPCU shall not disclose to another person any confidential information entrusted to, or obtained by, the CPCU in the course of the CPCU's business or professional activities, unless a disclosure of such information is required by law or is made to a person who necessarily must have the information in order to discharge legitimate occupational or professional duties.
- R6.3 In rendering or proposing to render professional services for others, a CPCU shall not knowingly misrepresent or conceal any limitations on the CPCU's ability to provide the quantity or quality of professional services required by the circumstances.

Canon 7

CPCUs Should Assist in Improving the Public Understanding of Insurance and Risk Management.

Rules of Professional Conduct

- R7.1 A CPCU shall support efforts to provide members of the public with objective information concerning their risk management and insurance needs and the products services and techniques which are available to meet their needs.
- R7.2 A CPCU shall not misrepresent the benefits, costs, or limitations of any risk management technique or any product or service of an insurer.

Canon 8

CPCUs Should Honor the Integrity and Respect the Limitations Placed upon the Use of the CPCU Designation.

Rules of Professional Conduct

- R8.1 A CPCU shall use the CPCU designation and the CPCU key only in accordance with the relevant GUIDELINES promulgated by the American Institute. R8.2 A CPCU shall not attribute to the mere possession of the designation depth or scope of knowledge, skills, and professional capabilities greater than those demonstrated by successful completion of the CPCU program.
- R8.3 A CPCU shall not make unfair comparisons between a person who holds the CPCU designation and one who does not.
- R8.4 A CPCU shall not write, speak, or act in such a way as to lead another reasonably to believe the CPCU is officially representing the American Institute, unless the CPCU has been duly authorized to do so by the American Institute.

Canon 9

CPCUs Should Assist in Maintaining the Integrity of the *Code of Professional Ethics*.

Rules of Professional Conduct

- R9.1 A CPCU shall not initiate or support the CPCU candidacy of any individual known by the CPCU to engage in business practices which violate the ethical standards prescribed by this *Code*.
- R9.2 A CPCU possessing unprivileged information concerning an alleged violation of this *Code* shall, upon request, reveal such information to the tribunal or other authority empowered by the American Institute to investigate or act upon the alleged violation.
- R9.3 A CPCU shall report promptly to the American Institute any information concerning the use of the CPCU designation by an unauthorized person.

PUBLISHER'S NOTE

IMPORTANT NOTICE

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