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LIFE & HEALTH PRINCIPLES

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PART ONE - LIFE INSURANCE PRINCIPLES

CHAPTER ONE

THE LIFE INSURANCE POLICY

Life insurance is a contract between an individual and an insurance company. In this contract, the insurance company agrees to pay a stated amount of money to a beneficiary, under certain conditions, in exchange for a sum of money called the premium.

It is important that you understand that a life insurance policy is in fact a legal contract. In other words it is an agreement between two parties to do something in exchange for the premium that is paid to the company.

THE USES OF LIFE INSURANCE

Life insurance is primarily used to function in personal and family situations.

As a rule a person's death creates an immediate need for money. The following is a list of some of the needs that might be created from a person's death.

- Expenses created by final illness.
- Burial and funeral expenses.
- Debts that are due at time of death.
- Costs to administer the estate.
- Federal and state death taxes.
- Inheritance taxes.

Money may also be needed to provide for the following:

- Payoff mortgages or purchases a new home.
- Provide an education for children.
- Meet unexpected financial needs.

Life insurance can also provide benefits for business situations.

Here are a few examples:

- Loss caused by death of a key employee.
- Collateral for loans.
- A business insurance fund.
- Buy-out business interest of a deceased owner.
- Fringe benefits for employees.
- Fund qualified retirement plans.

LIFE INSURANCE AS A PROPERTY

Very few people consider the fact that life insurance is a property. Where else could you make a premium payment of $100.00, and create an immediate estate or property valued at $250,000.00. That's possible with life insurance.

Here are some advantages of life insurance as property:

- As an asset it is very secure.
- There is no managerial care.
- It can be purchased in any desired amount.
- It provides a reasonable rate of return.
- Proceeds are payable immediately.
- You choose the method of payment for premiums.

THE LIFE INSURANCE APPLICATION

THREE PARTIES TO AN APPLICATION

A life insurance application contains three parties:

1. The proposed insured.
2. The applicant.
3. The policyowner.

1. **THE PROPOSED INSURED**
   This is the person whose life is being insured by the life insurance policy.

2. **THE APPLICANT**
   This is the person that is making application to the insurance company for the life insurance and remember may or may not be the proposed insured.

3. **THE POLICYOWNER**

This is the person that usually pays the premiums and the person who retains all rights to any values or options contained in the policy.

DEFINITION OF AN APPLICATION

In order for a person to purchase life insurance they must make a request to the insurance company of their choice. The form on which this request is made is known as an application.

Most companies now require that the proposed insured be physically present in front of the agent while the questions on the application are being filled out.

The application is crucial in that it provides the data that the underwriters and Insurance Company will use to determine if they will issue a policy.
When the proposed insured signs the application they are then making a formal request to the company that a policy be issued on their life.

In addition to this the signature on the application indicates that the information is true and correct to the best of their knowledge.

MINOR APPLICATIONS

In most states a person is not considered an adult until they are 18 years of age.

As a rule minors are not permitted to enter into contracts. However life insurance is the exception in that a person is a minor only until age 15.

In the event that the proposed insured is younger than age 15 one of the following persons must sign the application on behalf of that child:

1. Their mother or father.
2. A court appointed safeguard for the wellbeing of the minor.
3. Their grandparents.

CORRECTING APPLICATIONS

Should it be necessary to correct a mistake regarding information given on the application, the proposed insured must initial any and all changes on that application.

Mistakes on the application can be costly especially when the company is usually paying an outside reporting service to conduct an inspection.

Any changes that are made on a completed application must have the approval of the proposed insured.

The normal procedure is to return the incorrect application to the agent who in turn will take it to the insured to have the errors initialed.

INCORRECT / INCOMPLETE APPLICATIONS

Should an application contain incorrect or incomplete information it should not be taken lightly.

In the event that the company has already made a decision on a risk based on these inaccuracies it could result in a serious loss.

Should the error be discovered after the issuance of a policy the company can cancel or rescind the entire contract from the date of issue.

Of course this must take place before the incontestability clause of the contract takes effect.

REPRESENTATIONS / WARRANTIES

- All statements on applications are regarded as representations. When a person makes a statement that person believes to be true they are in effect making a representation of the truth.
- While it is possible that a representation may be found to be untrue, a person who makes a representation believes it to be true.
- A warranty on the other hand is a statement made with such absolute certainty that it is guaranteed to be true.
- No statement on an application is considered a warranty.
- Misrepresentation - A false representation can be defined as a misrepresentation.

FRAUD

There are three elements necessary to constitute a fraud. They are:

1. A person makes an intentional misrepresentation of what is known to be a material fact.

2. The person has intent to gain advantage.

3. And a person relied upon a second party that suffers a loss.

Remember there can be no fraud unless there was intent.

CONCEALMENT

Concealment is closely akin to misrepresentation when it comes to information included on a policy application.

While misrepresentation as stated earlier is something known to be untrue, concealment is withholding of facts that the applicant should have given to the insurance carrier at the time of application.

CONDITIONAL RECEIPT

It is best to always collect the first full premium from the applicant at the time of application.

The receipt that is located at the bottom of the application is called a conditional receipt.

The word "conditional" is very important because the agent is not guaranteeing that the policy will be issued.

Issuance of the policy is subject to the full approval of the insurance carrier.

The conditional receipt serves two functions:

1. It acknowledges the first full premium.
2. It states in very clear terms that the policy acceptance is subject to the approval of the carrier.

SHOULD THE INSURED DIE

In the event the proposed insured dies before the policy is issued, according to the conditional receipt, the following will take place:

- If the insurance carrier had issued the policy to the proposed insured had they still been living then the proceeds would be paid to the beneficiary.
- Should number 1 above not be the case and the claim is denied the premium will be returned to the beneficiary.

POLICY EFFECTIVE DATE

Full protection takes effect as of the policy effective date.
The policy effective date also begins the date on which the contestable period begins to run.

The policy effective date also is the date on which the suicide clause begins to run.

There are three reasons why the policy effective date is important. They are:

1. Insurance begins on this date.
2. The contestable period begins on this date.
3. The suicide begins on this date.

BACKDATING POLICIES

As a rule policies can be backdated a certain number of months. As a rule the maximum is to backdate six months. Most companies allow backdating for sales reasons.

FOR EXAMPLE:

- Oftentimes backdating can save an age by one year of the proposed insured and this can result in a lower premium for the proposed insured.
- Backdating is useful to assist the policyowner in coordinating dates to fit their income pattern. Perhaps the backdating may change the policy to closely match payday.

- Occasionally some policy forms have minimum and maximum age limits and backdating may be able to put the applicant's age into the window of acceptable age limits.

HOW MUCH LIFE INSURANCE DO I NEED?

The majority of families in America are inadequately insured.

In 1994 it was estimated that the average amount of life insurance enforced per family was only enough to keep that family going for 26 months following the death of the major financial supporter.

As a rule it is said that a person should carry life insurance equal to five or six times their annual earnings.

USING THE NEEDS APPROACH TO LIFE INSURANCE

The following are a few of the more popular applications for life insurance to provide for a need that occurs as a result of a death.

1. ESTATE SETTLEMENT NEEDS

Cash is needed for burial expenses, installment debt, administration expense, and estate tax and in some cases expense for the last illness.

2. READJUSTMENT PERIOD

Following the death of a head of family there is usually a one to two year period in which the family needs to continue to receive the same amount of income it would have received had the head of the family lived.

3. DEPENDENCY PERIOD

This period usually follows the readjustment period in that it lasts until the youngest child of the family reaches age 18.

4. BLACKOUT PERIOD

This is the period when social security benefits to a surviving spouse are temporarily terminated. This occurs when the youngest child reaches age 16 and will not resume until the surviving spouse reaches age 60.

5. SPECIAL NEEDS

Special needs may consist of a fund to pay off the mortgage, education fund for the children's education or an emergency fund for unexpected expenses.

6. RETIREMENT FUND

In this instance the head of a family may also wish to provide the surviving spouse with funds for retirement.

CHAPTER TWO

THE APPLICATION

Three terms with which you should become very familiar are Applicant, Insured, and Policyowner. The applicant is the person applying to the company for insurance, either on the applicant's own life of the life of another; the insured is the person whose life is covered by the policy; and the policy owner is the person who has the ownership rights in the insurance policy. The great majority of policies are issued on the application of the person to be insured who is also the owner of the policy.

In the typical situation, the policy owner, the applicant, and the insured will be the same person. There are, however, many policies issued where someone other than the insured applies for and owns the policy. The situation in which someone other than the insured is the policyowner is called "Third party ownership."

This type of arrangement is often found in family situations where, for example, a wife will insure her husband, or vice versa, or a parent will insure children. Third-party ownership is also often found in business situations, where a business insures the life of a key employee, for example. Another common third-party ownership arrangement is where a creditor owns a policy on the life of a debtor.

For a life insurance policy to be issued, an "**insurable interest**" between the insured and the policyowner must be present. In this regard, it is necessary to examine insurable interest from two standpoints. First, we'll look at the situation in which a person applies for insurance on the life of another. Then, we'll look at insurable interest when a person applies for insurance on his or her own life. First, let's examine the conditions that must be present to satisfy the insurable interest requirements in each of these situations.

Again, to purchase life insurance on the life of another, an insurable interest in the life of the proposed insured must exist. What that means is this; The policyowner must benefits, either emotionally or financially, by the insured continuing to live. Generally for an insurable interest to exist, the potential emotional loss must arise from love and affection which grows from a close blood relationship, or marriage. And, of course, where ones, own life is concerned, each person has an unlimited insurable interest in his or her own life.

Suppose that a life insurance policy could be sold when no insurable interest requirements existed. If a person could apply for insurance on the life of another

without this interest, then the policyowner would stand to gain, and suffer no emotional loss, by the insured's death. As such, a life insurance policy would constitute a mere wager which would be clearly against public policy, and therefore illegal.

Remember that an insurable interest arises out of a close blood relationship. While this is basically true, being the relative of a potential policyowner does not automatically establish an insurable interest. For example, under most circumstances, a person would probably find it difficult to establish an insurable interest in an aunt, uncle, or cousin unless the policyowner could show that a significant financial or emotional loss would result upon the death of the relative.

EXAMPLE:
Assume George has loaned a substantial amount of money to his cousin. George wants to purchase a life insurance policy on his cousin's life. George will be the policyowner, and his cousin will be the insured.

There is another important aspect of insurable interest; the relationship between a policy owner and a creditor. This relationship brings about another type of insurable interest.

A creditor can establish an insurable interest with a debtor. For instance, assume a bank loans $5,000 to an individual. Obviously, the bank will suffer financially if the debtor dies before the loan is repaid. This fact establishes the insurable interest between the bank and the debtor. For this reason, the bank can purchase life insurance on the life of the debtor and receive the death benefit of the life insurance policy, but only in an amount, which reflects the balance of the unpaid loan, should the debtor die prior to repaying the loan.

Insurance purchased by a creditor on the life of a debtor must be in an amount that approximates the size of the debt. So, if a debtor owes a creditor $1,000, it is unlikely that the creditor could purchase a $10,000 life insurance policy on the life of the debtor.

For this reason, most credit life insurance purchased on the life of a debtor has a reducing death benefit, which keeps pace with the diminishing loan balance. Therefore, if a debtor owes $5,000 to be repaid over a period of five years, the death benefit might begin at $5,000 to match the original amount of the loan. However, this policy would eventually reduce to $0 at the end of five years when the loan has been repaid.

COMPLETING THE APPLICATION

The application is a life insurance company document containing questions and information, which the company uses in evaluating the insurance risk and in properly preparing the policy if one, is issued. The agent completes the application by asking the applicant the questions.

The information requested on the application generally includes items such as the applicant's full name and address, age, sex, marital status, occupation, medical and family histories, present physical condition, and a description of the type and the amount of insurance applied for. It also includes the name of the person who is the beneficiary of the insurance along with data on other insurance owned and applied for, as well as whether or not the applicant was ever refused life insurance.

In view of the importance of the application, it is essential that the application be completed fully and accurately. If the application is incomplete, the underwriting process and policy issue will be delayed until the necessary information is obtained. And the company depends upon accurate information to make a proper evaluation of the proposed insured.

Finally, Sometimes an agent will need to correct the application. He or she may make a mistake in completing the form, or the applicant may remember some facts that require an addition to or change in the information already recorded. In such a situation, THE APPLICANT **MUST INITIAL** erasures, additions, or alterations of any kind.

CONCEALMENT, REPRESENTATIONS, AND WARRANTIES

As mentioned, the application is intended to reveal facts about the proposed insured that the company feels will be pertinent to making a decision about whether or not to insure the applicant. The insurance company uses the information supplied on the application, in large part, to make the decision about whether or not to issue the policy.

If the information submitted by the applicant is incorrect or incomplete, the insurance company may be forced to void the contract later on the grounds of concealment, material misrepresentation, or warranty violation.

CONCEALMENT occurs when an applicant conceals or fails to disclose known facts. To void a contract in most states, the concealment of facts by the proposed insured must be material to the selection of the risk, and it must be done with the intent to defraud. In other words, if knowledge of the concealed fact would have influenced the

company to accept or reject the risk, concealment has occurred and the contract may be voided.

CHAPTER THREE

TYPES OF LIFE INSURANCE

There are many types of life insurance available.

We will discuss the following:

- Term Insurance.
- Whole Life.
- Universal Life.
- Variable Life.
- Adjustable Life.
- Modified Life.
- Family Life.

TERM INSURANCE

This is the most basic type of life insurance. Some of its characteristics are as follows:

FIRST –
Term Insurance provides only temporary protection from one to 20 years or until the insured reaches a specified age. Should the insured be alive at the end of the term period the protection expires.

SECOND -
Term Insurance has no cash value or savings element. It is strictly pure protection.

THIRD -
Term Insurance can be renewable and convertible. Renewable means that you can continue the coverage for additional periods without proof of insurability. As a rule the premium increases each time the policy is renewed based on the age of the insured at the time of renewal.
Convertible means that the term policy can be exchanged for some type of cash value insurance without proof of insurability.

Term Insurance comes in a variety of policies. They are:

YEARLY RENEWABLE TERM –

This is issued for a one-year period and the policyowner has the right to renew coverage for successive one-year periods.

FIVE, TEN, FIFTEEN, OR TWENTY YEAR TERM –

Term insurance can be purchased for a specific period such as five, ten, fifteen or twenty years, and in some instances even longer periods.

The premium remains level during the policy term and should the policy be renewed at the end of the term the premium will increase.

TERM TO AGE SIXTY-FIVE OR SEVENTY –

In this instance the term insurance is provided to a stated age.

The premium remains level during the policy term and the insurance expires when the stated age is attained. As a rule the insured has the right to convert this term insurance to a cash value policy; however the policy must be converted sometime prior to the expiration date.

DECREASING TERM –

With a decreasing term policy although the premiums remain level during the policy term the face amount of insurance gradually decreases over time.

For example a $100,000.00 policy issued for a decreasing term of 30 years could decline to $50,000.00 by the end of the twentieth year and zero by the end of the thirtieth year.

REENTRY TERM –

This is a new type of term insurance that some companies make available. With this policy the premiums are based on a low-rate schedule.

Under the terms of this policy the insured must demonstrate evidence of insurability, usually every one to five years.

WHOLE LIFE

Whole Life Insurance has level premiums and will provide protection until age 100.

Some examples of Whole Life Insurance are:

ORDINARY LIFE INSURANCE –

Ordinary Life Insurance is a form of Whole Life. Lifetime protection is provided until age 100 and the premiums remain level. In the event the insured is still alive at age 100 the full-face amount will be paid without death having to occur.

LIMITED-PAYMENT LIFE INSURANCE –

This is another form of Whole Life Insurance. Although the premiums are level they are only paid for a certain number of years. After that payment period the policy becomes paid up. Limited-Payment policies can be issued for ten, twenty or thirty years.

A policy that is paid up at age sixty-five or seventy is still available. The premiums for Limited-Payment policies are higher than an ordinary life insurance policy but the cash value is also higher.

ENDOWMENT INSURANCE –

This is the third basic type of Whole Life Insurance.

An endowment pays policy proceeds to the named beneficiary if the insured dies within a certain period.

Should the insured survive to the end of the stated period, the policy proceeds are paid to the policyowner.

UNIVERSAL LIFE -

This form of Whole Life Insurance is becoming more and more popular.

Universal policies are sold as investments that combine insurance protection with savings.

Actually, a Universal Life Policy can be defined as a flexible premium deposit fund that is combined with monthly renewable term insurance.

Here's how it works:

FIRST –

An initial specific premium is paid. Then expenses are deducted from the gross premium and the balance is credited to the policy's initial cash value.

SECOND –

A monthly mortality charge is conducted from the cash value to pay for the pure insurance protection.

FINALLY -

The remaining cash value is then credited with interest at a specified rate.

Universal Life has the following basic characteristics:

- There are two forms available.
- Protection, savings, and expense components are separated.
- There is a stated investment return.
- Considerable flexibility.
- Cash withdrawals are permitted.

VARIABLE LIFE –

With a Variable Life Insurance policy, the face amount of insurance varies according to the investment experience of a separate account that is maintained by the insurer.

This is the perfect solution to the fact that inflation can quickly erode the real purchasing power of life insurance.

Under the Variable Life Insurance policy the premiums are invested in equities or other investments.

Should the investment experience be favorable the face amount of insurance is increased.

However should the experience be unfavorable the amount of insurance is reduced. In no event can the amount of insurance be reduced below the original face amount.

The Variable Life Insurance policy was designed to maintain the real purchasing power of the death benefit.

ADJUSTABLE LIFE

This type of Whole Life policy permits changes to be made in the following areas:

- Amount of life insurance.
- Period of protection.
- Amount of premium.
- Duration of premium-paying period.

This type of insurance is frequently called "**Life Cycle**" insurance because policy changes may be made to conform to different periods in the insured's life.

Within certain limits, the policyowner can make the following adjustments as the situations warrants:

- Reduce or increase the amount of insurance.
- Shorten or lengthen the period of protection.
- Increase or decrease the premiums paid.
- Lengthen or shorten the period for paying of premiums.

A cost of living provision can also be attached to the Adjustable Life Policy and this will in fact maintain the real purchasing power of the insurance.

MODIFIED LIFE

This is a type of Whole Life Policy in which the premiums are reduced for an initial period of three to five years and then the premiums increase thereafter:

The initial or reduced premium as paid in the beginning is slightly higher than Term Insurance rates but substantially lower than the premium paid for an ordinary Life Policy issued at the same age.

There are different types of Modified Life Insurance:

FIRST –
Under one type the Term Insurance is used for the first three to five years and then automatically converts into an ordinary life policy at a premium that will be higher than what would have been paid for a regular ordinary Life Policy issued at the same age.

SECOND –
Under another type, the approach is to redistribute the premiums by charging lower premiums during the early years of the policy but higher premiums thereafter.

Modified Life Insurance can be attractive to folks who expect their incomes to increase in the future.

FAMILY LIFE

This is a Whole Life Policy designed to insure all family members in one policy.
This policy is sold in units that state the amount and types of life insurance on the family members.

One unit for example may consist of the following:

- $5,000.00 of Ordinary Life on the head of the family.
- $2,000.00 of Term to sixty-five on the spouse.
- $1,000.00 of Term Insurance on each child up to stated age.

As a rule, Term Insurance under the Family Life Policy can be converted to some form of permanent insurance, typically the children's protection can be converted up to five times the face amount without proof of insurability.
Finally, there is no additional premium if another child is born and newborn children are usually automatically covered after a fifteen-day waiting period.

CHAPTER FOUR

KINDS OF INSURANCE COMPANIES

Life insurance companies can be organized in several ways; however, most are organized either as stock companies or as mutual companies.

A STOCK LIFE INSURANCE COMPANY

... Gets their name from its basic ownership characteristic. Its stockholders people, who have bought stock in the company, own a stock company. The stockholders may or may not also be policyowners. The sole function of the stockholders is to elect a board of directors who in turn will guide the operation of the company. If the company is successful financially, the stockholders will receive dividends, which are paid for each share of stock owned.

A stock life insurance company, like all other corporations, is in business to make a profit for the stockholders.

A MUTUAL INSURANCE COMPANY

... Is also a corporation, and it also derives its name from its basic ownership characteristic. Unlike a stock company, which is owned by its stockholders, a mutual company has no stockholders. Control in a mutual company rests with the policyowners who 'mutually" own the company. The policyowners elect a board of directors, and any "profits" are returned as dividends to the policyowners in the form of reduced costs for insurance.

It should be mentioned here that dividends from a mutual company are not profits in the mercantile or commercial sense but rather the return of an “overcharge”, of premium.

FOR EXAMPLE:

A mutual life insurance company might sell life insurance at one specific age for $20 per $1,000 of face amount. Once a dividend has been declared, each policyowner might then receive credit on the premium statement in the amount of $2 per $1,000. Thus, the resultant cost for the insurance is $18 per $1,000 of face amount.

While not true in every case, mutual insurance companies usually issue "participating" life insurance policies. The term participating means that if the company realizes a savings in death claims due to a lower mortality rate, or an increase in the interest earned, or if it realizes some efficiency in its operation which reduces expenses, these savings or "profits" are passed along to the policyowner in the form of' policy dividends. Thus, the policyowner in a mutual life insurance participates in any savings or "profits" enjoyed by the company.

You should never imply to a client that a stock company is better from an organizational standpoint than a mutual company, or vice versa, or that participating policies are better than nonparticipating ones. Both types of companies and both policies are good.

Before any life insurance company can sell insurance in any state, it must be licensed to sell insurance or, as it is called, **ADMITTED** to that state. An insurer that is admitted to a state is authorized to do business in that state. If an insurer is not admitted to a state, it is unauthorized to do business in that state.

Another type of insurer with which you should be familiar is the fraternal benefit society, also known as a “fraternal”. A fraternal insurer is a social and benevolent organization, which provides, among other services, life insurance benefits for members.

Membership in such an organization is often based on factors such as a person's nationality, religion, or occupation, but whatever the criterion for membership, keep in mind that fraternal have functions other than providing insurance.

Each state defines and provides for the regulation of fraternal benefit societies in its insurance laws. But, although the exact definition of a fraternal may differ from state to state, an organization usually must have certain characteristics to qualify as a fraternal benefit society. First, the organization generally must exist only for the benefit of its members and of their beneficiaries and be non-profit. Second, it must be organized without capital stock.

A third characteristic is that the society usually must be organized on a lodge system. This means that the organization must have local lodges or chapters, which hold regular meetings to carry on the activities of the society. Ritualistic ceremonies are often a part of those activities.

Finally, the organization must have a representative form of government. There must be a governing body chosen by the members directly or by delegates, in accordance with the organization's bylaws or constitution.

GOVERNMENT INSURANCE PROGRAMS .

... have been established for a variety of reasons throughout history. Social insurance programs have been created to allow the government to make compulsory a program lacking equity in order to cover fundamental risks and to redistribute income. Government insurance programs have been created when private insurers would have been subjected to adverse selection or were incapable of meeting society's needs.

By its administration of various Federal insurance programs, the U.S. government has become the largest insurer in the world. These various programs include Social Security, Medicare, and the Railroad Retirement, Disability, and Unemployment Programs.

RECIPROCALS . . .

. . . are groups of individuals (called "subscribers") who are insured under an arrangement where each subscriber is both an insured and an insurer. In other words, the other members of the group insure each subscriber. However, the liability of each subscriber is limited.

The administrator of the reciprocal is the "attorney-in-fact". He or she is granted this power by the subscribers through a broad power of attorney, and receives a percentage of the gross premiums paid by the subscribers. other than this payment to the attorney-in-fact and administrative expenses, the cost to the reciprocal is limited to the amount of the losses that occur. Any unused premiums are returned to the subscribers.

LLOYD'S OF LONDON . . .

. . . is a name familiar to many in the insurance industry. However, perhaps the most interest fact about Lloyd's of London is that it is not an insurer nor does it issue policies. Rather, Lloyd's of London is an association of members who write insurance for their own accounts. The New York Stock Exchange bears the same relationship to stock purchases as Lloyd's bears to the purchase of insurance.
Like the Stock Exchange, Lloyd's provides quarters for its members as well as procedures for business transactions. Though neither organization engages in trade, both provide facilities and rules that govern how its members will pursue trade. In addition, Lloyd's

maintains worldwide underwriting information and a complete record of losses. It also aids in loss settlements and supervises salvage and repairs throughout the world

At Lloyd's, an insurance transaction begins when a proposal is placed before the underwriting members, or their agents, by a licensed broker. The broker prepares the policy and submits it to the Policy Signing Office where the policy is examined. if the policy conforms to agreed-upon rules, it is submitted to the underwriters. Those underwriters who wish to participate in the policy affix their signatures or "underwrite", the risk. American Lloyd's associations operate under the same principles and methods as Lloyd's of London.

FINANCIAL STATUS OF INSURERS

Changing economic conditions and highly publicized failures of financial institutions (from savings and loan companies to insurance companies) have focused much attention on the financial status of private insurers. Independent rating services provide ratings consumers can use to measure the status of a company and compare it to others.

The two most popular rating services are A.M. Best Company and Standard and Poors. A.M. Best Company looks at profitability, leverage, and liquidity and assigns ratings from A++ (Superior) to C and C (Fair) and below. Standard and Poor's focuses on the claims paying ability of an insurer and offers ratings from AAA (Superior) to D (Insurers placed under an order of liquidation).

In most cases, insurance companies pay a fee to be rated by a rating service. Other rating services include Moody's Investors Service (measuring financial strength), and Duff and Phelps (measuring claims paying ability and managerial soundness). In addition to private rating services the National Association of Insurance Commissioners measures company performance and prepares analytical reports as part of the Insurance Regulatory Information System (IRIS). Agents have access to IRIS ratios, which serve as indicators of a company's financial condition in various areas.

CHAPTER FIVE

POLICY PROVISIONS OF LIFE INSURANCE POLICIES

It has been my experience in teaching live classes that ninety-five out of one hundred agents have never read the required policy provisions that are contained in every policy that they sell.

It is important that you realize that policy provisions are in fact contractual provisions and govern what the policyowner can and cannot do with the policy you have sold them.

Here is an overview of the list and then we will discuss them individually.

- Ownership Clause.
- Entire Contract Clause.
- Incontestable Clause.
- Suicide Clause.
- Grace Period.
- Reinstatement Clause.
- Misstatement of Age.
- Beneficiary Designation.
- Change of Plan Provision.

OWNERSHIP CLAUSE

The owner of a Life Insurance Policy can be the applicant, the insured, or the beneficiary. In most cases, the applicant and insured are the same person.

Under the Ownership Clause, the policyowner possesses all contractual rights in the policy while the insured is still alive. These rights include the selection of a settlement option, naming and changing the beneficiary designation, election of dividend options, and other rights.

These contractual rights typically can be exercised without the beneficiary's consent.

In addition, the ownership Clause provides for a change in ownership. The policyowner can designate a new owner by filling out an appropriate form with the company.

The insurer may require that the Life Insurance Policy be endorsed to show the name of the new owner.

ENTIRE CONTRACT CLAUSE

The Entire Contract Clause states that the Life Insurance Policy and attached application constitute the complete contract between the insurer and policyowner.

No statement can be used by the insurer to void the policy unless the statement is a material misrepresentation and is part of the application. In addition, any officer of the company cannot change the terms of the policy unless the policyowner agrees to the change.

INCONTESTABLE CLAUSE

Under the Incontestable Clause, the company cannot contest the policy after the policy has been in force two years during the insured's lifetime.
The insurance company has two years to discover any irregularities in the contract, such as a material misrepresentation or concealment.

If the insured dies after that time, the death claim must be paid. For example, if John conceals a cancer operation when the application is filled out and dies after expiration of the incontestable period, the death claim **WILL** be paid.

The purpose of the incontestable clause is to protect the beneficiary if the insurance company tries to deny payment of the death claim years after the policy is issued.

Since the insured is dead, allegations by the insurer concerning statements made in connection with the application cannot be easily refuted. After the incontestable period has expired, with few exceptions, the company must pay the death claim.

SUICIDE CLAUSE

A typical Suicide Clause states that the face amount of the policy will not be paid if the insured commits suicide within two years after the policy is issued. The only payment is a refund of the premiums.

The purpose of the Suicide Clause is to reduce adverse selection against the insurer by providing the insurer some protection against an individual who purchases a Life Insurance Policy with the intention of committing suicide.

GRACE PERIOD

A Grace Period is another important contractual provision. A typical

Grace Period gives the policyowner thirty-one days to pay an overdue premium.

The life insurance remains in force during the Grace Period. If death occurs during the Grace Period, the overdue premium usually is deducted from the policy proceeds.

REINSTATEMENT CLAUSE

If the premium is not paid during the grace period, a life insurance policy may lapse for nonpayment of premiums.

The Reinstatement Clause allows the policyowner the right to reinstatement of a lapsed policy under certain conditions:

- The insured must provide evidence of insurability, a condition that insurers often waive for lapses of less than two months.
- All overdue premiums plus interest must be paid.
- A policy loan must be repaid or reinstated.
- The policy has not been surrendered for its cash value.
- The lapsed policy must be reinstated within five years.

If the policyowner wishes to continue the same type of life insurance coverage, it usually is more economical to reinstate a policy than to buy a new one.
This is because a new policy is likely to have a higher premium, since it will be issued when the insured is older.

MISSTATEMENT OF AGE

The insured's age may be misstated in the application. Under the Misstatement Clause, the amount paid is the amount of life insurance that
the premium would have purchased at the insured's correct age.

FOR EXAMPLE:
Assume that Mary's correct age is thirty but is incorrectly recorded in the application as age twenty-nine.

Assume that the premium for an ordinary life application at age twenty-nine is $20.00 per $1,000.00 and $21.00 per $1,000.00 at age thirty.

If Jane has $15,000.00 of Ordinary Life Insurance and dies, only 14/15ths of the proceeds will be paid, or $14,000.00.

BENEFICIARY DESIGNATION

The beneficiary is the person or party named in the policy to receive the policy proceeds.

There are numerous Beneficiary Designations in life insurance.

They include the following:

1. The Primary Beneficiary is the first party who is entitled to receive the proceeds at the insured's death.

2. The Contingent Beneficiary is the beneficiary entitled to the policy proceeds if the primary beneficiary is not alive.

3. A Revocable Beneficiary designation means that the policyowner has the right to change the Beneficiary Designation without the beneficiary's consent.
4. An Irrevocable Beneficiary designation means that the policyowner cannot change the beneficiary without the irrevocable beneficiary's consent.
5. A Specific Beneficiary designation means that the beneficiary is named and can be identified. For example, Martha Smith may be specifically named to receive the policy proceeds if her husband should die.

6. A Class Beneficiary designation means that a specific individual is not named but is a member of a group to whom the proceeds are paid.

One example of a class Beneficiary Designation would be "children of the insured".

CHANGE OF PLAN PROVISION

The Change of Plan Provision allows the policyowner to exchange the present policy for a different one.

If the change is to a higher premium plan, such as exchanging an ordinary life policy for an endowment at age sixty-five, the policyowner must pay the difference in cash values between the two contracts plus interest at a stipulated rate.

Since the net amount at risk is reduced, evidence of insurability is not required.

Some insurers also allow the policyowner to change to a lower premium policy, such as exchanging an endowment contract for an ordinary life contract.

The insurer refunds the difference in cash values to the policyowner.

However, evidence of insurability is required since the net amount at risk is increased.

CHAPTER SIX

PREMIUMS

SINGLE AND PERIODIC PREMIUMS

There are two basic ways to purchase a life insurance policy.

THE FIRST –
is by paying the entire cost in one lump-sum payment. This is the "single premium" method.

THE SECOND METHOD –
of purchasing a policy is by the payment of periodic premiums. Rather than making a single payment for the insurance, the policyholder makes annual, semi-annual, or more frequent payments.

A single premium policy is seldom purchased because of the large lump-sum payment that is generally required. The typical policyholder finds the periodic payments much easier to make.

A second reason why single premium policies are seldom purchased concerns the cost of the policy if the insured dies in the early years of the contract. In this situation, the amount paid for the insurance under the periodic method will be less than the single premium amount.

PARTS OF THE PREMIUM

There are three basic factors, which affect the premium charged for a life insurance policy.

- **THE FIRST** is "mortality". Mortality refers to how many people within a given age group will die each year.

- **THE SECOND** factor is interest. Interest refers to the earnings the company receives on the premiums dollars it invests.

- **THE THIRD** factor is expenses. Expenses are, of course, all of the costs the company incurs in selling, issuing, and servicing its policies.

We said earlier that as one grows older, the cost of insurance increases. The reason for this is that as one grows older, the chance of death increases. Insurance companies use mortality tables and other statistics to determine the number of insureds, within each age group, who will die each year. What would happen if more people died in a year than the company had predicted? The company will pay out more for death claims than was anticipated.

Another factor, which influences the cost of insurance, is the interest income that the company earns from its investments.

Insurance companies receive millions of dollars each month in premium dollars. And, while each company has death claims, and other expenses, the costs for these claims and expenses should be less than the total premiums received.

By law, a life insurance company is permitted to invest this extra money to obtain additional revenue in the form of interest. Most life insurance companies invest in stocks, bonds, construction projects, and in a variety of other ventures designed to provide a return on their investment. The principal, as well as the interest earned, on these investments establishes a fund to pay all death claims as they occur and also helps to offset the cost of insurance.

In addition to savings which may result from lower than anticipated mortality, an insurance company may also realize income from investments.

Naturally, the insurance company is not permitted to keep all the money it receives. Expenses, of course, have to be paid. And, in addition to death claims, expenses include such items as:

1. Agent's commissions.
2. Salaries.
3. Advertising.
4. Physical examinations.
5. Legal costs.

6. Policy issue costs.

Here is a very simple formula, which indicates how these factors affect premium costs.

Death claims + other expenses - interest earned = premium to be charged.

Keep in mind that no company determines the premium to be charged by the simple method we have described above. This simplified approach merely describes the important relationship between these factors.

NET AND GROSS PREMIUM

The premium that a company charges for a life insurance policy is called the "gross" premium.

When a company is calculating the premium for a policy, it begins by determining the "net" premium. Once the net premium has been computed, the company then adds the expense factor, or "loading", to this net premium to arrive at the gross premium.

MORTALITY AND INTEREST FACTORS

Let's take a closer look at the two basic factors that go into the calculation of the net premium, beginning with the mortality factor.

An insurance company obviously cannot know when a particular insured will die. However, by using the mathematical concept of probability, the company can predict, with a great deal of accuracy, the number of insureds who will die each year. This prediction of future mortality is made on the basis of past mortality experience and assumes that future experience will parallel past experience. But, if past mortality is to be a reliable basis for prediction, accurate data must be kept on a large group of representative individuals for a sufficiently long period of time.

Information on past mortality is analyzed and arranged in a table, called the “mortality table" which shows probable death or mortality rate at a specific age.

Beginning with a given number of individuals at a given age, the mortality table shows the number of people out of the group who probably will die at each age and the number who will survive.

Remember that even if the mortality rates and the mortality table are accurate, a company, which wants a reliable estimate of future mortality, must apply the rates to a large enough group of individuals for the "law of averages" to operate.

LEVEL PREMIUM CONCEPT RESERVES

Once the net single premiums is computed, the company then converts that premium into a "net level premium" since few policies are purchased by the single premium method. Lets now turn to the concept of level premiums.

The early renewable term premium also called "natural or step-rate" premium, increases each year as the insured ages and the risks of mortality increases. The premium rises rather gradually during the younger ages, but increases sharply for the older ages. As a result, the premiums can become prohibitively expensive for most insureds at the older ages.

To overcome the problem of annually increasing premiums, companies develop the level premium plan. With this plan, the premium remains the same during the premium payment period rather than increasing as the probability of death increases. This level premium is higher than the natural or yearly renewable term, premium in the early years of the policy but is lower than the natural premium in the later years.

Under the natural premium plan, the net premium charged policyowners each year is just sufficient to pay the expected claims for the year. This is not true for the level premium plan. The net level premium payments made in the early years of the contract are greater than the amount needed to pay the policy claims during those years.

By investing the excess part of the premium in the early years, the company accumulates funds to cover the deficiency, which occurs in the latter years. These funds which the company holds to meet future policy obligations constitute the policy reserve or simply the "reserve".

The reserve is the amount that, together with future premiums and interest earnings, will be sufficient for the company to pay all future policy claims, based on the company's mortality and interest assumptions. Thus, the reserve is a liability - future obligation to the company.

Because a company's ability to fulfill its contract obligations depends upon sufficient policy reserves, the state requires a company to maintain certain minimum reserves.

State laws specify the mortality table and the assumed rate of interest to be used in calculation of the legal minimum reserves.

Because of these state regulations, reserves are often called "legal reserves".

INSURANCE AGE

Premium charged for life insurance depends upon the insureds age. This is true because the mortality factor is one of the three basic elements of the premium and the mortality factor varies with an insureds age.

However, the age used to determine the premium is the insured's insurance age. The insured's insurance age may, or may not, be the same as his or her actual or chronological age.

A Company may use one of two methods of determining an insurance age.
In the first method, an insured's insurance age is his or her age at the insured's nearest birthday. If the insured turned age 30 less than 6 months ago, the insured's age would be 30. However, if the insured's 30th birthday was more than 6 months ago, the insurance age would be 31 since the next birthday would be nearer than the last.

Although the nearest birthday is the more commonly used method, some companies may use the insured's last birthday to determine the insurance age. The insurance age under this method is the same as the insured's actual age, regardless of the number of months since his or her last birthday.

CHAPTER SEVEN

EXCLUSIONS AND RESTRICTIONS ON LIFE POLICIES

Life insurance policies contain very few exclusions and restrictions. The more common ones are as follows:

A. Certain activities which are considered dangerous such as flying, hang-gliding, auto racing or skydiving may either be excluded or covered if an additional premium has been paid.

B. A Suicide Clause excludes payment of the face amount in the event of suicide within two years of the issue date.

C. An Aviation Exclusion may be present in the policy and would exclude death coverage from an aviation accident other than as a passenger on a regularly scheduled airline.

D. The War Exclusion is designed to control adverse selection during times of war and may be inserted to exclude payment if death occurs as a result of war.

PAYMENT OF PREMIUMS

The policyholder of a life insurance contract has a choice as to how they may pay premiums. Premiums can be paid annually, semiannually, quarterly, monthly direct or monthly bank draft.

The company usually offers a discount for paying the premiums annually. The most popular method of payment is monthly bank draft.
Monthly direct billing quarterly follows the method that causes the most lapses. The method that best suits persistency is monthly bank draft followed by annually.

CHAPTER EIGHT

SETTLEMENT OPTIONS

When benefits are paid following the death of the insured the payments of benefits is referred to as Settlement of the Policy.

The following is an overview of the settlement options and then we will review them one at a time.

They are:

- Lump Sum Settlement.
- Proceeds and Interest.
- Fixed Years Installments.
- Life Income.
- Joint Life Income.
- Fixed Amount Installments.
- Other Mutually Agreed Methods.

LUMP SUM SETTLEMENT

This is when the beneficiary receives the policy proceeds in a single payment following the death of the insured.

PROCEEDS AND INTEREST

Under this option the insurance company will hold the policy proceeds and make interest payments to the beneficiary.

The minimum interest rate is spelled out in the policy and the company may at its discretion to pay a higher rate.

The beneficiary still has the right to withdraw all or part of the proceeds of the policy at any time.

FIXED YEARS INSTALLMENTS

With this option the insurance company pays the proceeds in equal monthly payments. The recipient of the proceeds chooses the number of years for which payments will be made.

The amount received monthly depends on three factors:

1. Policy proceeds.

2. Number of years payments are to be made.

3. Interest rate paid by the insurance company.

Again under this settlement option the beneficiary still has the right to withdraw all or part of the proceeds at any time.

LIFE INCOME

Under this settlement option the beneficiary will receive equal monthly payments for the life of the beneficiary.

The amount of monthly payments depends on four factors:

1. Policy proceeds.

2. Beneficiary's sex.

3. Beneficiary's age at time payments begin.

4. Period certain for which payments are guaranteed.

Should payments be guaranteed f or a period certain, such as ten years, payments will be made for the specified number of years regardless or whether the beneficiary lives to the end of that period.

Should the beneficiary die during the period certain payments will continue to the beneficiary's designated successor.

FOR EXAMPLE:
A beneficiary is going to receive $500.00 a month for 10 years certain. This means that should the beneficiary live the entire ten years he will receive $500.00 a month.

After ten years there are no more benefits paid.

However should the beneficiary die in the sixth year the remaining four years of $500.00 per month will go to his designated successor.

JOINT LIFE INCOME

When this option is chosen equal monthly payments will be made so long as either one or two payees is alive.

This option may be used when a policyowner / insured contributes to the support of his or her parents. In the event of the insured's death, the parents, as beneficiaries, would receive monthly income for the rest of their lives.

The amount of the monthly benefits would depend on two factors, which are:

- The policy proceeds.
- Parents' ages at time they begin to receive benefits.

However under this option the beneficiaries typically do not have the right to discontinue the monthly payments and receive the balance in a one-sum settlement.

FIXED AMOUNT INSTALLMENTS

Using this settlement option, the insurance company makes equal payments per month, or at longer intervals, in an amount chosen by the policyowner or beneficiary.

All proceeds held by the insurance company will earn interest. If the monthly payment is greater than the monthly interest earned, the balance of the proceeds held by the insurance company decreases each month until the total proceeds and interest due are paid out.

Under this option the beneficiary may withdraw the unpaid balance at any time.

If the beneficiary dies before the installment payments are completed, the unpaid balance is paid to the beneficiary's estate.

OTHER MUTUALLY AGREED METHOD

On occasion a life insurance company may allow the policyowner to designate other payments methods if the insurance company agrees them to.

An example of this may be that the proceeds at interest are to be paid to the insured's spouse for the spouse's lifetime and, upon the spouse's death, a one-sum settlement is to be made to the insured's children.

CHAPTER NINE

NON-FORFEITURE OPTIONS

Life insurance policies contain non-forfeiture options.

They are designed to give the insured ways in which he or she may gain continued value from a policy in the event the insured is unable to continue premium payments.

The five non-forfeiture options are as follows:

1. Cash Surrender Value
2. Reduced Paid up Insurance.
3. Extended Term Insurance.
4. Automatic Loan Provision.
5. Dividend Accumulations to Avoid Lapse.

CASH SURRENDER VALUE

A policyowner may surrender their policy and request that the company pays them the cash surrender value of the policy if any.

As a rule most policies have no cash value whatsoever for the first two to three years. The Cash Surrender Value usually consists of the following:

- The policy cash value.

- Cash value of paid up additions.
- Dividends.

The Cash Surrender Value can be reduced by:

- Any policy loans that are outstanding.
- Accrued loan interest on outstanding policy loans.

It is important to know that all coverage ceases when the policy is cash surrendered.

Payment is usually made in one lump sum and in some cases in accordance with one of the other policy settlement options already discussed.

REDUCED PAID-UP INSURANCE

Under this option the policyowner may request that the cash value of the policy be used to keep a reduced amount of paid-up insurance in force under the same policy.

Usually the policy has a table contained in it that shows the amount of reduced insurance in any given year that the cash value that same year would purchase.

Although the policy has had its face reduced the policy will continue to earn cash value and pay dividends if applicable.

EXTENDED TERM INSURANCE

This option allows the same face amount of the policy to remain in effect for a specified number of years and days. Again as with reduced paid-up insurance the policy will contain a table showing how long in years and days the original face amount will remain in force during any given surrender year.

The length of time in years and days is calculated by taking the policy's cash surrender value, the insured's age and sex at the time premiums were discontinued and using that cash surrender value to purchase term insurance for a specified amount of years and days.

Under this option the policy does not continue to earn cash value or pay dividends if applicable.

AUTOMATIC PREMIUM PROVISION

It is possible for the insured to authorize the insurance company to make an automatic loan from the policy's cash value to pay any premium not paid by the grace period.

DIVIDEND ACCUMULATIONS TO AVOID LAPSE

Should the policy pay a dividend, then the dividend accumulations may be applied to any premium not paid by the end of the grace period. In the event the amount of accumulated dividends is not enough to pay the entire premium, coverage will then be extended in proportion with the amount of premium paid by the accumulated dividends. As a result of this a new grace period will start at the end of extension coverage.

CHAPTER TEN

DIVIDEND OPTIONS

If a life insurance contract is a participating policy that means that the policyowner is entitled to an annual dividend paid by the insurance carrier.

Participating policies affords the policyowner the opportunity to participate in the earnings of the insurance company through dividend payments.

The following are the ways in which a policyowner may use his or her dividends:

- Cash Payment.
- Reduction of Premium.
- Accumulation at Interest.
- Paid-up Additions.
- One-year Term.

USE OF DIVIDENDS

CASH PAYMENT

Under this dividend option the insurance company sends the insured a check equal to the amount of the declared dividend payment.

REDUCTION OF PREMIUM

The premium due on the policy for the upcoming year will be reduced by the amount of the current years declared dividend and the balance becomes the new premium due for the upcoming year.

ACCUMULATION OF INTEREST

The dividend may be held by the insurance company to accumulate with interest paid at the rate that is specified in the contract.

The insured has the right to withdraw the accumulated dividends at any time.

Should the accumulated interest and dividend be on deposit with the company at the time of the insured's death, the accumulated interest and dividend will be paid along with the policy proceeds.

PAID-UP ADDITIONS

This option enables the insured to receive additional amounts of life insurance by using the dividend to purchase paid-up additions.

The additional insurance will be the same kind and subject to the same provisions as the original policy.

Again on the insured's death paid-up additions of insurance will be paid up along with the policy proceeds.

ONE-YEAR TERM

Some policies permit dividends to purchase one-year term coverage.
The amount of the one-year term coverage would be added to the face amount of the base policy in the event of the insured's death.

CHAPTER ELEVEN

LIFE INSURANCE POLICY RIDERS

Most of us are familiar with the term "endorsement". However in life and health insurance the word "rider" is used in lieu of endorsement.

The effect is the same in that riders modify the coverage of the basic policy the same as an endorsement would.

The most commonly used riders in life insurance policies are:

- Waiver of Premium.
- Accidental Death and Dismemberment.
- Guaranteed Purchase Option.

COMMON LIFE INSURANCE RIDES

WAIVER OF PREMIUMS

This rider protects the insured in the event he or she becomes totally disabled.

The waiting period is usually six months and if the insured continues to be disabled after the six-month waiting period the premium payments on the policy will be waived.

Many policies will also refund the premium that was paid by the insured during the six-month waiting period.

The cost for this coverage is a bargain to say the least and no policy should be sold without this rider.

ACCIDENTAL DEATH AND DISMEMBERMENT

The amount paid in the event of accidental death of the insured is usually the same as the policy's regular face amount.

Therefore if death occurs as the result of an accident the beneficiary receives twice the amount of the face value of the policy.

Some agents may better recognize this benefit when it is referred to as “double indemnity”.

As a rule the accidental death rider is very carefully worded to define exactly under what circumstances this benefit will be paid.

The most liberal of the definitions is "accidental bodily injury." The less favorable wording would be that death must occur “by accidental means”.

For example using "by accidental means" if an insured died from a broken neck after intentionally diving into the shallow end of a swimming pool the policy would not pay the accidental death benefit because the action of diving into this pool wasn't accidental.

However if the insured accidentally fell into the pool and drowned the benefit would be paid. Under the "accidental bodily injury" definition the intentional diving into the pool would have been paid.

Normally the death caused by the accident must consummate itself within ninety to one hundred eighty days of the incident.

Under the dismemberment rider payment is made to the insured rather than the beneficiary.

Benefits typically are paid for:

- Loss of Sight.

- Loss of Hand or Hands.
- Loss of Foot or Feet.

Regarding the loss of hand or foot, the loss typically must involve "complete severance through or above the wrist or ankle joint".

Loss caused by amputation is excluded unless medically necessary and as the result of an accidental injury.

GUARANTEED PURCHASE OPTION

This option is used most frequently with whole life insurance rather than term insurance.

Under this option the company guarantees the insured that he or she may purchase additional amounts of coverage without evidence of insurability.

These additional purchases are usually made at specific time intervals or events that change your family status.

For example some policies permit additional purchases of life insurance under the following circumstances:

- Every Fourth Policy Anniversary Year.
- The Insured Purchases a New Home.
- The Insured gets Married.
- The Birth of a New Child.

The premium charge for the additional coverage is typically based on:

- The Type of Insurance Purchased.
- The Insured's Age at Time of Exercising Option.

CHAPTER TWELVE

LIFE INSURANCE UNDERWRITING

The purpose of life insurance underwriting is to develop a profitable book of business for the insurance company.

In order to accomplish this goal the life insurance underwriter attempts to provide coverage for a diversified group of insureds whose expected death rate is the same or lower than what is expected of the population as a whole.

UNDERWRITING FACTORS FOR INDIVIDUAL COVERAGE

Life insurance is priced on a class basis. Perspective clients of the insurance company are classed on the basis of a number of factors that help to predict expected mortality rates.

The principal rating factors are:

- Age.
- Sex.
- Health
- Occupation and Avocation.
- Personal Habits.
- Foreign Travel or Recent Immigration.

AGE

Mortality rates are measured in terms of deaths per one thousand persons and this of course increases with age.

Thus the older you are the more life insurance costs because you are closer to death than a younger person.

SEX

Women in the United States live seven years longer than men.

Therefore cost for life insurance on a woman is lower than on a man of the same age.

For example a thirty-year old male would pay the same premium as that of a thirty-three-year old female.

HEALTH

The health of an individual as well as the health history of their family helps the underwriter to determine if the applicant presents an average or better than average risk to the insurance company.

In evaluating an insured's health the company will consider whether the applicant or family members have had any of the following illnesses:

- Cancer.
- Heart Disease.
- Hypertension.
- Diabetes.

As a rule persons whose health history include the above diseases will likely have a higher than normal mortality rate.

Most insurance companies are now offering discounted rates to non-smokers due to the link between smoking and lung and heart disease.

OCCUPATION AND AVOCATION

Since certain occupations pose hazards such as flying and scuba-diving applicants who engage in these hobbies are likely to have a higher than normal mortality rate.

PERSONAL HABITS

If a life policy exceeds $100,000.00 in coverage the insurance company will more than likely investigate the personal circumstances of the insured's life.

For example areas such as alcohol or drug use, poor driving record or financial problems may be taken into consideration.

FOREIGN TRAVEL OR RECENT IMMIGRATION

People who travel or reside outside the United States may be exposed to diseases not commonly found in this country.

Additionally mortality rates vary from country to country. Therefore if a person is applying for life insurance shortly before leaving the country special medical tests or a postponement of coverage may take place.

UNDERWRITING ACTIONS

Based on the information that the underwriter receives from the applicant one of three actions may be taken.

They are as follows:

- Rate the Applicant Standard and Charge the Normal Premium.
- Rate the Applicant Substandard and Charge a Higher Premium.
- Decline the Coverage.

In addition to the above three actions many insurance companies recognize preferred risks and they will actually reduce premiums.

CHAPTER THIRTEEN

DELIVERING THE POLICY

POLICY EFFECTIVE DATE

The effective date of a life insurance policy is very important since this is the date on which coverage begins.

The policy effective date may also have additional significance with regard to the incontestable and suicide clauses.

The incontestable clause gives the insurer, usually two years, that amount of time to contest the policy on the basis of material misrepresentation, fraud, or concealment in the application.

The suicide clause excludes coverage for death by suicide during the first two years of the policy.

To determine the effective date of the policy, we must examine the principal of contract law known as "offer and acceptance".

If a proposed insured signs the application and submits it with the first premium to the company, an offer to buy insurance has been made by the proposed insured.

If the insurance company issues the policy, as applied for, then the fundamental of offer and acceptance occurs. That is, the proposed insured has made an offer to purchase a life insurance contract, and the insurance company has accepted that offer.

So far, we have assumed that the premium was submitted with the application. However, there are two other possibilities to consider regarding the effective date of the policy.

The first occurs when an application is submitted without the premium. In this case, the applicant has made no offer. The applicant has only extended an invitation to the Company to make an offer.

The insurance company makes the offer when it issue a policy as applied for and delivers it to the applicant. Further, the offer is accepted when the applicant pays the premium, assuming any other conditions have been fulfilled and this date becomes the effective date of the policy.

In situations where the initial premium does not accompany the completed application, most companies state in the application that the proposed insured must be in good health at the time of policy delivery before coverage becomes effective.

So, before accepting the initial premium and leaving the policy, the agent must obtain a signed statement of the prospective insureds continued good health. This statement and the initial premium are then transmitted to the company.

The final possibility occurs when the premium is submitted with the application but no receipt is given. If this is the case, then the policy's effective date is generally date that the policy is issued and delivered.

Delivery of the policy constitutes the company's acceptance of the applicant's offer - the application and initial premium.

A POLICY IS CONSIDERED IF...

- The policy is actually handed over in person.
- Is mailed to the policyholder.
- Is mailed to the agent for unconditional delivery to the policyholder

Delivery, then, does not usually have to be accomplished by the manual transfer of the policy to the policyholder.

Delivery accomplished by means other than a manual transfer is called "constructive delivery".

If a policy is not, or cannot, be delivered as defined previously, then the policy is not in effect, as policy delivery has not been accomplished.

Two other situations need to be addressed.

FIRST. . .
. . . when the applicant wants to examine the policy for a time before paying the initial premium, and the policy is left with the applicant for inspection, he or she should sign a receipt for the policy referred to as an "inspection receipt". This acknowledges that the policy is in the insured's possession for inspection purposes only and that the initial premium has not been paid and that the insurance is not in effect.

SECOND. . .
. . . is backdating. An applicant may ask the company to give the policy for which they are applying a date earlier than the application date. The reason for backdating is usually to obtain a lower premium. Premium paid for life insurance depends, among other factors, on the insured's age. So, in order to obtain a lower insurance age, and, as a result a lower premium, backdating is used.

AGENTS RESPONSIBILITIES

The agent should deliver the policy to the client as soon a possible after the policy is issued. This is especially important when no premium was submitted with the application because the coverage will not become effective until the policy is delivered and the first premium paid during the continued good health of the proposed insured.

The agent also has a responsibility to explain the policy's provisions, riders, and exclusions.

If the policy is rated, the agent should explain why the policy was issued that way.

CHAPTER FOURTEEN

DEFINITIONS USED IN LIFE INSURANCE PLANS

A

AGE CHANGE –
The point in the 12 months between natural birthdays at which the individual is considered to be of the next higher age for the purpose of insurance rates. Most life insurers consider that point as halfway between birthdays. Health insurers frequently use the age at last birthday until the next birthday is actually reached.

AGE LIMITS –
The ages below or above which an insurer will not issue a given policy.

AGENT –
An individual appointed by an insurer to solicit, negotiate, effect or countersign insurance contracts on its behalf. (See also Producer)

ALIEN COMPANY OR INSURER –
An insurer organized and domiciled in a country other than the United States.

APPLICANT –
The party submitting an application to an insurer for an insurance policy.

ATTAINED AGE –
The age an insured has reached on a given date.

B

BENEFICIARY –
A person, who may become eligible to receive, or is receiving, benefits under an insurance plan, other than as an insured.

BENEFICIARY CHANGE –
A change in the policy which alters the previous beneficiary designation. Must be made by formal application to the insurer. Compare to Beneficiary, Irrevocable.

BENEFICIARY, IRREVOCABLE –
A named beneficiary whose status as beneficiary cannot be changed without his or her permission.

BENEFICIARY, PRIMARY –
The person first designated to receive the proceeds of a policy, as named in the policy.

C

CANCELLATION –
Termination of the insurance contract by voluntary act of the insurer or insured, effected in accordance with provisions in the contract or by mutual agreement.

CARRIER –
The insurance company that "carries" 11 the insurance. The term "insurer" is preferred.

CASH SURRENDER VALUE –
In life insurance, the value in a policy that is the legal property of the policyowner, and which the policyowner may receive if the policy is surrendered for cash. Synonymous with cash value.

CLAIM –
The demand of an insured or his or her representative or beneficiary for benefits as provided by an insurance policy.

COMMISSION –
The portion of the premium stipulated in the agency contract to be retained by the agent as compensation for sales, service, and distribution of insurance policies.

CONCEALMENT –
The withholding, by an applicant for insurance, of facts that materially affect an insurance risk or loss.

CONDITIONAL RECEIPT –
Provides that if the premium accompanies the application, the coverage is in force from the date of the application (whether the policy has yet been issued or not)

provided the insurer would have issued the coverage on the basis of facts as revealed by the application and other usual sources of underwriting information.

CONTINGENT BENEFICIARY –
Person or persons named to receive benefits if the primary beneficiary is not alive at the time the insured dies.

D

DEATH BENEFIT –
The policy proceeds to be paid upon the death of the insured.

DEATH CLAIM –
A formal request for payment of policy benefits occasioned by the death of the insured. Should be made through the agent, but may be made directly to the home office. Requires a copy of the death certificate as proof of death and is made by the beneficiary.

DECLARATION PAGE –
The portion of an insurance policy containing the information regarding the risk.

DECREASING TERM INSURANCE –
Term insurance for which the initial amount gradually decreases until the expiration date of the policy, at which time it reaches zero.

DEFERRED ANNUITY –
An annuity on which payments to the annuitant are delayed until a specified future date.

DOMESTIC COMPANY –
An insurer formed under the laws of the state in which the insurance is written.

DOUBLE INDEMNITY –
Payment of twice the basic benefit in event of loss resulting from specified causes or under specified circumstances

E

EFFECTIVE DATE –
The date on which an insurance policy goes into effect.
ENDORSEMENT –
Technically, a change made directly on the policy form by writing, printing, stamping or typewriting and approved by an executive officer of the insurer. In general use, also may refer to a change made by means of a form attached to the policy.

ESTATE –
Assets of an individual comprising total worth. Includes any life insurance in force.

EXCLUSIONS –
Stated exceptions to prior provisions in a policy. Common exclusions in health policies include pre-existing conditions, suicide, self-inflicted injuries, and many others. In life policies, common exclusions are death through flying in a private airplane, riot, or state of war.

EXPIRATION -
The date upon which a policy's coverage ceases.

F

FACE AMOUNT -
The amount indicated on the face of a life policy that will be paid at death or when the policy matures.

FAMILY PLAN POLICY –
An all-family plan, usually with permanent insurance on the father's life, with mother and children automatically covered for lesser amount -usually term -- all paid by a single premium.

FOREIGN COMPANY –
An insurer organized under the laws of a state other than the one where the insurance is written.

FRAUD –
An intentional misrepresentation made by a person with the intent to gain an advantage and relied upon by a second party which suffers a loss as a result.

G

GRACE PERIOD –
A period of time after the premium due date during which a policy remains in force without penalty even though the premium due has not been paid. Commonly 30 or 31 days in life insurance policies; seven, 10, or 31 days in various health insurance policies.

H

HOME OFFICE –
The place where an insurance company maintains its chief executives and general supervisory departments.

I

INSURABILITY –
The condition of the proposed insured as to age, occupation, physical condition, medical history, moral fitness, financial condition and other factors that makes the individual an acceptable risk to an insurance company.

INSURABLE INTEREST –
In life and health insurance, the interest of one party in the possible death or disability of an insured that would result in a significant emotional or financial loss. Such an interest must exist in order for the party to purchase insurance on the life or health of another. In property-casualty insurance, a financial interest is property.

INSURANCE DEPARTMENT –
A governmental bureau in each state of territory (and federal government in Canada) charged with administration of the insurance laws, including licensing, examination, and regulation of agents and insurers. In some jurisdictions, the department is a division of some other state departments or bureau.

INSURED –
The party to an insurance contract to whom, or on behalf of whom, the insurer agrees to indemnify for losses, provide benefits, or render service.

INSURER –
The party to an insurance contract that undertakes to indemnify for losses provides other pecuniary benefits, or render service. Also called insurance company and sometimes-insurance carrier.

L

LAPSED POLICY –
A policy for which the policyholder has f ailed to make the premium payment during the grace period, causing the coverage to be terminated.

LICENSE, AGENTS –
A state-conferred license that enables an insurance agent to do business in the conferring state. Renewable annually. Subject to an initial written examination and to suspension or revocation for certain offenses.

LIFE EXPECTANCY –
Average number of years of life remaining for persons at any given age.

LIFE INSURANCE –
Insurance pays a specified amount upon the death of the insured to the insured's estate or to a beneficiary.

LOAN VALUE –
The amount of cash value reposing in a policy which may be borrowed by the insured.

M

MISREPRESENTATION –
On the part of an insurer or its agent, falsely representing the terms, benefits, or privileges of a policy. On the part of an applicant, falsely representing the health or other condition of the proposed insured.

MORTALITY RATE –
The average number of people who die each year.

N

NON-FORFEITURE OPTION –
A legal provision whereby the life insurance policyowner may take the accumulated values in a policy as (1) paid-up insurance for a lesser amount (2) extended term insurance; or (3) lump-sum payment of cash value, less any unpaid premiums, or outstanding loans.

NON-PARTICIPATING POLICY –
A policy that does not provide for the policyowner to share in dividends. Also called a nonpar policy.

NON-RESIDENT AGENT –
An agent licensed in a state in which he or she is not a resident.

O

ORDINARY AGENT –
An agent selling ordinary life insurance.

ORDINARY LIFE INSURANCE –
Life insurance other than group life. Ordinary life may be either permanent or temporary term.

P

PAID-UP INSURANCE –
A non-forfeiture option in life insurance policies under which insurance exists and no further premium payments are required.

PARTICIPATING POLICY –
A policy in which the policyowner receives a share of policy dividends. Also called par policy.

PERMANENT INSURANCE –
Life insurance with some type of cash value accumulation.

POLICY LOAN –
A loan to the policyholder from the insurer using the insurance cash value as collateral.

PRE-AUTHORIZED CHECK PLAN –
An arrangement under which the policyowner authorizes the insurer to draft his or her bank accounts for the (usually monthly) premium.

PRIMARY BENEFICIARY –
The beneficiary named first to receive proceeds or benefits of a policy that provides death benefits.

PROOF OF DEATH –
A usual requirement before paying a death claim is that a formal proof of death form of some type be submitted to the insurer.

R

REBATE –
Giving or offering to give something of value other than the benefits of a policy as an inducement to buy insurance, a practice illegal in all states except Florida.

REINSTATEMENT –

(1) Putting a lapsed policy back in force, sometimes requiring the payment of back premiums and evidence of insurability, (2) In some health policies, reinstating or restoring the amount of benefits available when the payment of claims has reduced the principal amount of the policy by the amount of the claims. Provision is usually made for a method of reinstating the policy to its original amount. This may be done automatically either with or without premium consideration or at the request of the insured. Often found in-group health contracts and may be called restoration of benefits.

RIDER –
An amendment attached to a policy that modifies the conditions of the policy by expanding or decreasing its benefits or excluding certain conditions from coverage.

S

SETTLEMENT OPTION –
A method of receiving life insurance proceeds other than a lump sum.

STANDARD RISK –
A risk that meets the same conditions of health, physical condition and morals as the tabular risks on which the rate is based without extra rating or special restrictions.

SUICIDE CLAUSE –
In a life insurance policy, states that if the insured commits suicide within a specified period of time, the policy will be voided. Paid premiums are usually refunded. The time limit is generally one or two years.

T

TERM INSURANCE –
Life insurance that normally does not have cash accumulations and is issued to remain in force for a specified period of time,, following which it is subject to renewal or termination.

U

UNIFORM POLICY PROVISIONS –
A set of standardized provisions used in health insurance policies, of which 12 are required and 11 are optional. All states use these provisions, although they are permitted to revise the wording as long as it is at least as beneficial to the insured as the original wording.

W

WAIVER OF PREMIUM PROVISION –
When included, provides that premiums are waived and the policy remains in force if the insured becomes totally and permanently disabled.

WHOLE LIFE –
Permanent life insurance on which premiums are paid for the entire life of the insured.

PART TWO - HEALTH INSURANCE PRINCIPLES

CHAPTER ONE

THE ART OF FILING HEALTH INSURANCE CLAIMS

HOW TO FIRST SORT OUT YOUR 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 –
YOU NEED TO DETERMINE THE TYPE OF POLICY YOU HAVE AND IF BENEFITS ARE COORDINATED.

Millions of people have more than one insurance policy; therefore, it is necessary to file your claims in proper order. In order to avoid lengthy claims processing and delays, or worse yet, have legitimate claims denied, you must be certain you file 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 you have more than one policy, you need to determine which one is your primary.

SECONDARY OR SUPPLEMENTAL POLICIES

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

Provide your supplemental or secondary insurance company with evidence of what your primary policy has paid. That evidence is the EXPLANATION OF BENEFITS, (EOB) you receive from your primary insurance company.

Always understand the order in which your policies coordinate benefits. NEVER send claims to your supplemental or secondary insurance plan until you have received the explanation of benefits from your primary plan. If you do, you will be creating unnecessary paperwork and will not receive any additional payment.

STILL UNCERTAIN OF THE DIFFERENCE BETWEEN PRIMARY AND SECONDARY COVERAGE?

If you are employed and have coverage under more than one insurance plan, you may have difficulty understanding, which of your policies is primary, and how your 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.

If you are confused about how your secondary or supplemental policy coordinates benefits, call your insurance company claims department. You may also want to call toll-free directory assistance to see if your insurance company has a toll-free service number in your area.

If you have more than one insurance policy and continue to be in doubt over the filling order for your health insurance claims, do not hesitate to call your state department of insurance for help.

Make sure you discuss the following when you call:

- Explain the policies you have to the state department of insurance representative. The representative will then confirm the order in which you should file the claims with your insurance carriers.

- Record the filling order on your Supplemental, Secondary, or Medicare Supplement Health Insurance Coverage and place them with your polices in a safe place.

CATASTROPHIC HEALTH POLICIES

Catastrophic health policies usually provide secondary or supplemental coverage and provide benefits after a high deductible is met. If you have a catastrophic policy, record the name of that policy in a safe place. You will also want to keep track of your cumulative medical expenses to determine when you 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 you are hospitalized or disabled and do not have coordination of benefits clauses. Most indemnity polices allow you to file claims when they are incurred for covered expenses. If you have an indemnity policy, record the name in a safe place with your other insurance policy papers.

CONFIRMING YOUR COVERAGE AND BENEFITS BY PHONE

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

If you can't quickly find or understand the information in your policy handbook, here is a fast way to confirm that you need to know for accurate claims processing. When you follow these tips, you should be able to prevent mistakes and quickly collect all the reimbursements you are entitled to collect from your insurance company.

First call your insurance company's claims department to confirm your coverage and learn how to file your medical insurance claims for your current or anticipated medical bills. If you are covered by more than one plan, call each insurance company.

TO SAVE TIME:

- If your insurance company's telephone number is continually busy during the day, try calling at a non-peak time such as early morning.

- If Medicare covers you, there is no reason to call to confirm your coverage and filing requirements in advance. Hospitals, clinics, physicians, and other health care providers are required by Medicare to file your claim directly. When you call your insurance company claims representative, be prepared to give your name and policy number.

- Then, be prepared to discuss your current or anticipated medical condition and your insurance deductible, policy provisions, coverage areas and file requirements with the claims representative.

The following is a detailed review of what to discuss with your insurance company representative to confirm quickly over the phone what you need to know for each of your health insurance policies. Be sure to take notes on what you confirm and put them in a safe place with your other insurance information.

MAKING SURE OF YOUR DEDUCTIBLES

Always confirm how your deductible is calculated. Make notes concerning the specified amount of certain costs that are your responsibility before you can expect to receive any reimbursements. These can include your 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 you incur a $300 bill, the insurance company may only consider $150 of

that bill to be reasonable and customary. As a result $150, not $300 is applied to your deductible.

If you have more than one policy, each may have a different way of figuring its deductible. You should make records of what you find and keep this also in a safe place for future reference in filing your claims and evaluation of your reimbursements.

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 your deductible renewal periods with your insurance company claims representative. Remember to record this information for future reference.

PREPARING A MASTER CLAIM FORM WILL SAVE TIME

Once you have confirmed your coverage and recorded what you need to know on each of your health insurance policies, you will save considerable time when filing future claims by preparing a Master Claims form for each of your policies.

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.
- The signature of the insured.

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.

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 you avoid this confusion.

ORGANIZE AND KEEP TRACK OF YOUR MEDICAL EXPENSES

You are the one responsible for ALL of your medical bills! Whether you or your hospital physician or other medical provider files your health insurance claims, you will need to keep track of all expenses. You 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. You must begin by sorting all your 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 you will be sure that you are collecting all the reimbursements to which you are entitled.

Always record all of your bills, even if your doctor, hospital or other providers are filing them directly to your insurance company.

- First, 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.

- Fill in the name of the physician, hospital laboratory, pharmacy, medical supply company, ambulance, dentist, or physical therapist.

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

PREPARING AND KEEPING TRACK OF YOUR INSURANCE CLAIMS

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

Be sure your policy covers the bills you are about to submit You can quickly check your coverage by examining the notes you took when you called your insurance company claims representative. Ideally, you remembered to keep these notes in a safe place and all together. If a bill is not covered by your policy, write, "not covered". Then pay

your bill if you have not already done so and save the copy of the bill in the file folder you made earlier marked "Closed claims".

Save time when submitting your claim. Get your Master Claim form from your primary health insurance coverage file. You should have made some copies of this form for future use, but if not, do so now and return the original Master Claim form to your file. Then answer any remaining questions pertaining to the bills you are submitting for reimbursement (i.e. your diagnosis, treating physician, date of illness and the date the claim form is being submitted).

Check your bills and other paperwork before attaching them to your now completed claims form. Be sure to attach to your 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 your 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 your policy number on each and every piece of paper you submit. Given the amount of paperwork insurance companies receive, this will prevent loss if your paperwork gets separated at the insurance company. Also, don't forget to list the bills submitted directly by your hospital, clinic, physician or other medical providers in your records. If your provider filed your claim, you will probably not know the date the claim was filed, so enter the date you are recording the provider's bill in your records as the date the claim was submitted. Then circle the date to remind yourself that the provider filed for you.

ALWAYS! ALWAYS! ALWAYS! ALWAYS!

- . . . Make a photocopy of each bill claims form and any supporting material for your files before sending anything to your insurance company. To make your file copies quick and easy to locate in your "open claims" file, prepare a follow-up sticker such as a Post-it note and jot down these reminders.

- The date you are submitting the claim or recording the bills your provider has submitted for you.

- The name of the insurance company receiving the claim.

- Clip your bills and any supporting material together and affix your follow up sticker to the top copy. Place the bins in your "Open claims ' file in chronological order by the dates on the follow up sticker. Once again, get in the habit of recording your bills and claims and keeping this record in a safe place with all of your insurance records and policies, etc. When you do, you will always save time and frustration whenever you need to locate your bills and other materials to file with your secondary or supplemental plans, resubmit a lost claim, check the accuracy or reimbursements or remedy denied or underpaid claims.

UNTANGLING WHAT YOU OWE AND YOUR REIMBURSEMENTS

If you are like most people, when insurance company Explanation of Benefits begins to arrive, you are 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 you with medical services have been directly paid by your 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, match the dates and the amounts on each Explanation of Benefits statement you receive with the service dates and charges you entered in your record. You will want to note in your records whenever you 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 you recorded earlier in the first column.

- In the next column, 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 you receive payment.

- Indicate "provider" if the provider received a check directly from the insurance company.

- Never endorse an insurance check to a hospital physician or other provider. Always issue your own personal check or bank charge so you have a record of payment if there is an error in crediting your account.

FILING WITH YOUR SECONDARY OR SUPPLEMENTAL INSURANCE POLICIES

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

Begin by referring to your coverage notes and filing instructions on the work sheets and records you have kept on file. These notes are the ones you made when you originally phoned your insurance company representative. If you haven't made that call do it now and fill in your notes and records. If your notes show that your additional insurance policy (or policies) coordinates benefits with your primary plan you will have to wait to submit bills for additional reimbursements until you have received your primary carrier's Explanation of Benefits.

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

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

- Photocopy the Master Claims form you have kept in your claims file. Then answer any remaining questions about the bills you 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.

- You can easily locate the paperwork you will need to photocopy for any particular claim by referring to the original date the claim was filed that you noted in your records. Look for that date on the follow up sticker on the paperwork stored in your file folder marked "open claims".

- Be sure to put your policy number on every piece of paper you submit.

- Again, record the date that you are filing your claim to your back up insurance carrier and put a follow up sticker on your file copies with this date on it.

- Clip your copies together and store them in your open claims file in chronological order.

A FINAL REVIEW OF YOUR FILE

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

- Check for unpaid balances. If you see unpaid balances in your 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 your providers. If your insurance company has paid your provider, check to see if you owe any balance to your provider. If you have not paid your provider and have received an insurance reimbursement check, pay your provider the amount you initially recorded in your notes, then note this payment in the same records.

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

CHAPTER THREE

UNDERSTANDING MEDICARE CLAIMS

DETERMINE IF MEDICARE IS YOUR 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 YOUR PRIMARY PLAN IF:

- You are retired or not working full-time.

- You are working fail time, are enrolled In an employer group been insurance plan and your company has less than 20 employees in the work force, or

- You are enrolled in your spouses employer group plan, and there are less than 20 employees in your spouse's work force.

MEDICARE WILL BE YOUR SECONDARY PLAN IF:

- You are working full time, are enrolled in your employer's group health plan and there are 20 or more people in your employer's work force. or,

- Your spouse is working full time, and you are covered as a dependent in your spouse's employer group plan and there are 20 or more people in the work force of your spouse's employer.

HOW YOUR MEDICARE CLAIMS ARE FILED

IF MEDICARE IS YOUR PRIMARY PLAN:

IF YOU ARE AN INPATIENT:

- Your hospital will file your Medicare claim for you and it will receive payment directly from Medicare. All you need to do is provide your Medicare number at the time you are admitted to the hospital.

- Your hospital will bill you for your "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, you will be billed for co-payments at Medicare specified amounts. Following hospitalizations, skilled nursing facilities will file for you only if you meet the criteria set by Medicare for approval

YOU ARE AN OUTPATIENT:

- Your hospital or clinic also will file your Medicare claim for you. Again, all you need to do is give your Medicare number to your hospital or clinic.
- Medicare will pay for 80 percent of your charges if your deductible has been met.
- You 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 your claim directly with Medicare. Again, all you need to do is give them your Medicare number.

- When your providers files your claim, they must tell Medicare how they want to be paid.
- When your providers accept Medicare assignment, they will receive payment directly from Medicare.
- Your provider's fees will become whatever fees Medicare approves.
- Medicare will send your provider 80 percent of the Medicare approved amount after your deductible has been met.

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

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

- You will be billed for the total cost of the health care services your received.
- You will be responsible for paying your health care provider's entire bill.
- You 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 YOUR BACK UP PLAN?

Here is how your claims are filed.

IF YOU ARE AN INPATIENT

- Your hospital will file the necessary claims with Medicare for any unpaid balances not paid by your primary insurance carrier.
- All you need to do is provide both your primary insurance information and your Medicare number at the time of admission. Be sure to tell the hospital that Medicare is your secondary coverage.

IF YOU ARE AN OUTPATIENT

- Your hospital or clinic will file with Medicare for any unpaid balances not paid by your primary insurance.
- All you need to do is provide your Medicare number to the hospital or clinic and advise them that Medicare is your secondary coverage.
- If your primary carrier pays your hospital or clinic directly, your hospital or clinic will file your claim with Medicare for any unpaid balance.
- If your primary carrier reimburses you for your outpatient hospital or clinic charges:
- You will need to provide your hospital or clinic with the Explanation of Benefits your primary carrier has sent you. They will then file your Medicare claim for the unpaid balance.
- Be sure to pay your hospital or clinic what your primary plan has paid you by your own personal check or bank charge.

Physician or other provider responsibilities:

- Ask your physicians or other providers whether they accept Medicare assignment.

- If your provider accepts Medicare assignment send the provider your primary carrier's Explanation of Benefits. The provider must then submit a claim directly to Medicare.

- If your provider does not accept Medicare assignment submit your itemized bills with your primary carrier's Explanation of Benefits to Medicare for payment on the unpaid balance. You will receive payment directly from Medicare.

UNDERSTANDING THE MEDICARE EXPLANATION OF BENEFITS

Keeping track of Medicare paperwork can be a major job. Often you 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 you must make sure that all your providers are paid and that you have collected all you are entitled to collect. For each and every charge you have for medical services, you need to match...

- Who provided you with specific medical service on various dates and their charges with what you have paid them and what balances you still owe them?

- Whether Medicare has processed all the charges submitted by your providers with what Medicare has paid, the accuracy of payments and who received payments.

- What charges your Medicare supplement or your secondary carrier with what your Medicare supplement has paid, the accuracy of payments and who received payments has processed.

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

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

- The dates of service for each individual bill.

- The names of your doctors or other providers.

- The amounts of each bill (make sure you list each item if the bill is itemized) this will help you interpret your Explanation of Benefits when it arrives.

- Write Medicare or any names of Medicare supplement or other insurance policies you may have.

- The date that you are submitting the claims.

- Again, sort all bills by date order, prepare your Master claims form by filling in all information you can that is not related to your bills. Make copies of your Master claims form then fill out the copies with the information directly related to each bill. Attach all bills and any additional information you may have that is related to that bill **AFTER YOU HAVE MADE COPIES OF EACH AND EVERY PIECE OF PAPER**. (Also, again, make sure you have written your policy number and / or Medicare number on each bill). This is to protect against your paperwork getting separated at the insurance company.

And to make your medical bills, claims, and other paperwork easy to find when you need them prepare a sticker with the date you have listed the bills in your record that your provider filed with Medicare and write "Medicare" and affix the sticker to your bills. Then clip your bills together and place them in chronological order by the dates on your follow up stickers. When you do, you will quickly be able to find your paperwork in the file folder you have prepared for "open claims". Whenever you need to file with your Medicare supplement and / or other insurance policies after your Explanation of Medicare Benefits arrives, verify the accuracy of reimbursements, identify and remedy denied or underpaid claims or arrange to have lost claims resubmitted.

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

As you receive your Explanation of Medicare Benefits, you will want to make notes in your 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 you have matched the EOMB with your charges, record the amount that Medicare paid for the charge in the last column of your records. This will be 80 percent of the Medicare approved amount once your Medicare deductible has been met. Don't let yourself 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 you 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 your provider charged on a Medicare non-assigned claim (i.e. when the provider wants to be paid by you and not Medicare) you may want to request that Medicare review the claim for a possible error.
- Record the date of the Explanation of Medicare Benefits computer printout. Then check who received the payment from Medicare in your records? Again check "me" or "provider".

CAUTION

Again, never endorse a Medicare check to a doctor or other provider. Always issue your personal check or bank charge so you have a record of payment. If there is an error in crediting your account to help you understand what you are responsible for paying your physicians and other medical providers, make notes in your records.

FOR EXAMPLE. . .

. . . copy the total Medicare approved amount from your Explanation of Medicare Benefits. This is especially important for those who have Medicare supplements that pay to the Medicare approved amount. If the physician or medical provider accepted Medicare assignment, write "accepted assignment" in your record and copy the amount you owe the provider from your Explanation of Medicare Benefits. If you have not met your Medicare deductible, write "applied to deductible" and the amount being applied to your deductible. You will also want to record how much you have paid the provider and the date of your payments in your record. Often this date will be the date of medical service, or before your insurance company provides you with reimbursement. Other times, you will be paying this amount after you or your provider has collected from your insurance company.

When a provider accepts Medicare assignment, you may not receive the provider's bill until after you receive your 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 YOUR MEDICARE SUPPLEMENT

If you have a Medicare supplement or secondary insurance, never submit a claim until after you have received your Explanation of Medicare Benefits that details what Medicare has paid on your claim. That is because your Explanation of Medicare benefits is the official proof your other insurance carrier needs to process your 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 keep your records up to date and all your paperwork organized in dated order in your file marked "open claims". This will help you avoid paperwork nightmares when provider's final bills are received.

To assure yourself that you will get full reimbursement on all your claims, always call your Medicare supplement's claims department to confirm what you are entitled to collect. Then record what your learn in your notes.

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

- Does my Medicare supplement policy have a deductible?

  If it does, ask:

  - The dollar amount of the deductible.
  - How the deductible is calculated?
  - How often your deductible must be renewed?
  - What does my 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 your Explanation of Medicare Benefits with your policy identification number at the top of the page. Others require that you submit a claims form with your Explanation of Medicare Benefits and copies of all your itemized bills, notes of medical necessity and so forth.

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 your 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 your provider's number.

- Be certain that the diagnostic code is correct, (it's possible to obtain a list of these codes from your doctor).

- Should your 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 you have purchased from your insurance carrier.

- The amount you were charged is more than what is considered "usual reasonable and customary" for your geographic area.

- You received a service considered by your carrier to be routine, but in fact, were 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 yours.

FAILURE TO FOLLOW THE CARRIER'S REGULATIONS

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

A couple of examples are as follows:

- Some hospital admissions require that you obtain a pre-certification from your carrier. (Except in emergencies, of course). A telephone call to your carrier can help solve this problem.

- Should you 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 you 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 YOU KNOW THE REASON FOR DENIAL OR UNDERPAYMENT

You have the following remedies available to you in this situation:

- Dispute over coverage. Call your 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 your 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 your physician or other provider, can be corrected by simply requesting that a corrected statement be sent to

you. Again, be certain that all pertinent information previously discussed, diagnostic code, provider's name, etc. is contained on the corrected bill.

SENDING LETTERS TO YOUR INSURANCE CARRIER

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

Therefore your letter should contain the following:

- Be certain you have the correct address of the insurance company.
- Be certain your name and address for return correspondence is in your letter.
- Your policy number.
- Your claim number.
- Directed to the attention of a specific department if possible.
- Better yet directed to an individuals 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 include your 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 you have received a negative resolve to your dispute, you have one final step.

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

CHAPTER FIVE

GETTING SQUARED AWAY WITH YOUR PROVIDERS

UNPAID MEDICAL BILLS

Your providers such as physician, clinic or hospital expect to receive payment for services rendered to you. I'm sure you will agree this is fair and reasonable.

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 your behalf 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 you and your family. For the most part these folks will grant some patience in waiting for payment. However, should you find a health provider insensitive to your financial

situation, or one that refuses to work out a payment plan, contacting an attorney may be your best avenue.

BE UP FRONT WITH YOUR 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. You might want to give your health provider evidence that all the money you have received from your insurance carrier has been properly applied to those due the money.

Often, an understanding provider will accept what the insurance carrier has paid them 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 your hospital bill for errors is always a good idea.

Look for the following:

- Supplies never given to you.
- 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 your carrier feels that the charge was excessive and did not fail within the "usual reasonable and customary" fee, contact your 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, your claim is paid for a lesser amount.

Here is what to do should this happen:

- Was there a service given to you 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 you 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 us as follows:

- Lack of information. You can never give too much information, but in fact, most claims do not have enough.

- Knowing what your 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.

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 faculty 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 1990, there were approximately 6.9 million Americans, 65 or older, who required long term care. And by the year 2030, that 6.9 million figure will be 19 million plus!

By 2050 more than 1 million will reach the age of 100 years old. The 21st century will see a dramatic increase in the size of the older population as the larger baby boomer population retires. Studies show that, eventually, one out of every two of us may need some form of long-term care. Increasingly people will be turning towards private long-term care insurance to ensure access to quality affordable long-term health care.

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 advise 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.

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

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.

CHAPTER NINE

NON-FORFEITURE OPTIONS FOR LONG TERM CARE

As the popularity of long term care polices grow, the insured is going to have to be afforded non-forfeiture options that protects their policy values and benefits and protects them from forfeiting same. Life Insurance policies currently contain these three non-forfeiture options, but, the wording of these non-forfeiture options will be different for long term care policies.

The three non-forfeiture options are:

CASH VALUE

This would provide a guaranteed amount to be paid to the insured should the policy be surrendered or lapsed.

REDUCED PAID UP

This would provide that the daily benefit be reduced for the policy's benefit period and that the insured not be required to continue payment of premiums.

EXTENDED TERM

Extension of coverage for the full amounts that the policy would have ordinarily paid without any future payments of premiums for a limited extension of time.

Another type of non-forfeiture option that has come upon the long-term care scene is a cash back feature. Under this provision, an insured might typically receive 50, 60, 70, or 80% of total premiums paid upon discontinuing the policy either by surrender or having the policy lapse. Of course, as is the case in most cash back features, claims paid are deducted from the amount of returned premiums.

CHAPTER TEN

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 us 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 ion 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 axe 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 povision is usually part of all disability contracts. It states that if the insured is disabled more that 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 ELEVEN

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 axe 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

May 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 TWELVE

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 l8 months.

CHAPTER THIRTEEN

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 FOURTEEN

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 FIFTEEN

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.

PUBLISHER'S NOTE

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